

# THE UNINSURED

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## HEARING

BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

MARCH 9, 2004

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## **THE UNINSURED**

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**TUESDAY, MARCH 9, 2004**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 2:25 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

# ADVISORY

## FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE  
March 02, 2004  
HL-5

CONTACT: (202) 225-3943

### Johnson Announces Hearing on the Uninsured

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the uninsured. The hearing will take place on Tuesday, March 9, 2004, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Douglas Holtz-Eakin, Director of the Congressional Budget Office, and experts on the uninsured population and health insurance. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

#### **BACKGROUND:**

This hearing will focus on Americans who lack health insurance coverage—a constantly changing group as some gain and others lose coverage. Estimates of the number of uninsured range from 20 to 60 million, depending upon the definition of uninsured, and the length of time considered. For example, the Congressional Budget Office estimates that between 21 and 31 million people were uninsured for all of 1998, about 40 million were uninsured at any point in time during 1998, and nearly 60 million were uninsured at some point in 1998. According to analysis by the Census Bureau, the number of non-elderly who were uninsured increased each year from 2000 to 2002, after falling the previous two years.

The uninsured are not all alike: they encompass a wide range of characteristics. While some uninsured tend to have lower than average income, and tend to be in poorer health, others are young and healthy. Over 50 percent of the non-elderly who were uninsured at any time during 1998 had incomes over 200 percent of the poverty level. In 1998, 90 percent of those who were uninsured all year were in working families.

In announcing the hearing, Chairman Johnson stated, “When Americans who lack health insurance coverage get ill, many suffer lower access to care and higher costs. We must understand who lacks coverage and why, before we can identify solutions to the problems the uninsured face when they need health care.”

#### **FOCUS OF THE HEARING:**

The hearing continues the Subcommittee’s consideration of the issues concerning Americans who lack access to affordable health insurance. The first panel will discuss the identification of individuals without health insurance and changes in the number uninsured over time. The second panel will help Members understand the causes and consequences of lack of health insurance, tax and regulatory policies that affect access to health insurance, and consequences faced by some of the uninsured who are hospitalized. This hearing will lay the groundwork for future hearings on options to address the problems of the uninsured.

#### **DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please note:** Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to [hearingclerks.waysandmeans@mail.house.gov](mailto:hearingclerks.waysandmeans@mail.house.gov), along with a

fax copy to (202) 225-2610, by the close of business, Tuesday March 23, 2004. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse unopened and unsearchable deliveries to all House Office Buildings.

#### **FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to [hearingclerks.waysandmeans@mail.house.gov](mailto:hearingclerks.waysandmeans@mail.house.gov), along with a fax copy to (202) 225-2610, in WordPerfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

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Chairman JOHNSON. Good afternoon. The hearing will come to order. Today's hearing focuses on uninsured Americans, who they are, and why they are uninsured. Since the Subcommittee on Health last held a hearing on the uninsured in 2001, the number of Americans without coverage has increased. Over 43 million Americans, more than 1 in 7, are uninsured on any given day. In my home State of Connecticut, more than a quarter million residents live and work without health insurance. As we develop legislative solutions, we need to understand the latest research on the uninsured and the barriers they face in purchasing coverage.

We will hear from our expert panelists that the uninsured are a dynamic group which is constantly changing as people gain and others lose coverage. The number of Americans who are uninsured depends on the definition of the uninsured, especially how long a person is uninsured and whom you count. Analysis by the Congressional Budget Office (CBO) shows that if you look at people who are uninsured for an entire year or longer, you find between 21 million and 31 million uninsured. If you look at any given day in a year, about 40 million are uninsured. If you consider those who are uninsured at any point during a year, nearly 60 million are uninsured.

The uninsured are a diverse and divergent group demographically as well. Among the non-elderly who are uninsured all year, one-quarter are under age 18, but one-fifth are over 45. Three-quarters have income less than two times the poverty level, but 5 percent have income four times the poverty level. One-quarter lack a high school diploma, but one-third attended college.

One characteristic may come as a surprise to many. About 90 percent of the uninsured live in working families, and 40 percent live in families with a full-time worker. Over 60 percent of uninsured individuals do not have access to insurance through their employer, often a small business. In Connecticut, for example, 59 percent of the uninsured adults work for companies with fewer than 100 employees and 30 percent, or 76,000 people in Connecticut, work at a company with fewer than 10 employees.

Finally, some of the uninsured are eligible for public programs but fail to enroll. For example, one-third of uninsured children were eligible for Medicaid. Others are eligible for the Children's Health Insurance Program (CHIP). The presence of the uninsured is a significant problem in our Nation's health care system. The Subcommittee understands the importance of addressing this problem, both because those without health coverage often go without health care and because the payment structure supporting our providers no longer accommodates the cost shifting that used to absorb the cost of care of the uninsured. Indeed, for the individual uninsured person, he or she is more than three times likely to delay care, more than three times likely to leave a prescription unfilled, and far more likely to face financial ruin as a result of health care costs than an insured individual.

From the point of view of the provider network, emergency rooms are closing and doctors are being forced to limit the number of non-payers they accept for care as costs rise and payments fall. So, both for the sake of the individual uninsured people in America and to preserve our health care delivery capability for all, we must assure that every American has access to affordable health care. Today our experts will help us review the who, when, and why questions about the uninsured so that we may turn at a later date to the question of how to fix the problem.

First we will hear testimony from the director of the CBO, Douglas Holtz-Eakin, who will focus on the diversity of the uninsured, and, given that diversity, the multiple approaches in the future we will have to consider. Actually he is not going to consider the multiple approaches. I sort of misread my punctuation there. I say that, given that diversity, I believe we will be required to approach this problem from many different points of view. Our second panel will turn to further examination of the uninsured population and our experts will discuss barriers to affordable coverage and myths about the uninsured. I would like to recognize Mr. Stark, the Ranking Member, for an opening statement.

Mr. STARK. Thank you, Madam Chair. I appreciate your calling this hearing. I must admit it feels a little bit like Ground Hog Day. Year after year we hold hearings and report on the uninsured and year after year we hear that the numbers continue to rise. Year after year we fail to take any action. I say that through a series of various Administrations and political control. We know who the



uninsured are and we know why they are uninsured and we could fix it.

Even President Bush knows how to get there, and that is why he is promoting national health insurance for the people in Iraq. It may sound strange that I agree with the President on something, but in this case his idea that a system of national insurance is the most equitable, efficient means of insuring all people is right. I only wish that he would decide to extend that same generosity to his folks here at home so that everyone in our great country could have the benefits of a national health insurance program.

My friend and our own Secretary of Health and Human Services has basically said that Americans deserve less than national insurance. A week ago, when he was asked about our policy in Iraq, he said, well, and I am quoting him: "Even if you don't have health insurance in America, you get taken care of." I am not sure what that means, "taken care of." That could be defined as universal health care. I find it alarming that our Administration would equate eventual treatment in an emergency room or a charity clinic, often too late to avoid serious damage or death, as universal health care.

We know better than that. The Institute of Medicine will tell us that 18,000 Americans die prematurely each year due to the effects of lack of health insurance coverage. The Kaiser Family Foundation in their 2003 health insurance survey found that half of uninsured adults postpone seeking medical care, and over a third say they need it but did not get medical care in the last year. Their survey also found that a third of the uninsured had a serious problem paying their medical bills in the past year and a quarter were contacted by a collection agency, if not having homes foreclosed or threatened with bankruptcy.

The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided. "Sicker and Poorer: The Consequences of Being Uninsured," a report by the Kaiser Commission on Medicaid and the Uninsured, found that better health would improve annual earnings by 10 to 30 percent for private companies.

The statistics go on. We know how to solve the problem. We have programs that work in this country. They work in the State of Hawaii. They are up above 95 percent covered, which is far better than we are able to do. We have employer-sponsored insurance for workers. We have got public programs such as Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Consolidated Omnibus Budget Reconciliation Act (COBRA). We could build on those programs. All we need is somebody in the White House and their adherence here and in the Senate to roll up our sleeves and say, let's do it. We could go to work tomorrow and require some kind of, I don't care what it is, pay or play. We could do it, there is nothing new in this world of providing medical care to all Americans. It ought to start right here and I would love to join with the Chair and introduce a bill next week and let's see how far we can go. Thank you.

Chairman JOHNSON. Thank you, Mr. Stark. I hope that our testimony today will create a better factual basis for legislative action. Dr. Holtz-Eakin.

**STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D., DIRECTOR,  
CONGRESSIONAL BUDGET OFFICE**

Dr. HOLTZ-EAKIN. Chairman Johnson, Mr. Stark, Members of the Committee, thank you for the chance for CBO to be here today and present some of the work we have done on the uninsured. I have a written statement which I will submit for the record and I will instead use this time to touch briefly on the highlights, some of which the Chairman has introduced in her opening remarks.

Probably the easiest way to do this is through the use of the four charts that we brought along. The first chart is focused on the question of how many people are uninsured. The answer really depends on how one asks the question. One could ask the question, How many people are uninsured for an entire year, for a full year? If the question is asked that way, using data from three different surveys—and these data are from 1998 but recent research suggests the basic patterns are unchanged—you would have an answer of roughly 20 to 30 million individuals who are uninsured for the entire year.

In contrast, you could ask the question, How many people experience some spell of uninsurance during a year, however short or long? If one asked the question in that way, you get a much larger number, about 60 million individuals. Those are the bars on the right-hand side of the chart. Instead what you typically hear is the number 40 million. That is the answer to the question, if you walked out on the street and asked how many people are uninsured in this week or on this day, there would be a mixture of those two groups: those who have short spells and long spells, and that number is about 40 million individuals.

As these numbers suggest and as we show in Chart 2, there are radically different experiences in terms of the duration of spells of uninsurance. For some individuals, about 45 percent, the duration of such a spell would be under 4 months. That is shown as the large wedge in the pie chart on the left. In contrast, about 29 percent, nearly 30 percent of individuals experience a spell of uninsurance that exceeds 1 year in length. The remainder lie in between.

As a result of this mixture of individuals with short and long spells, if you walk out on the street again and find a person who is not insured and ask the question, How long would this person be uninsured, you are more likely to find somebody who has a long spell of uninsurance because of their prevalence in the population and that is displayed on the right-hand pie chart. The policy implications of this, I think, are fairly straightforward. One size evidently does not fit all and it suggests that there are really broadly two different kinds of problems of uninsurance: those with short spells perhaps driven by labor market dislocations and job transitions; and those with longer spells which exceed a year in length.

The next question is, What do the individuals look like in these different spells? This is laid out in Tables 1 and 2 in the testimony. The highlights of that are that adults are more likely to suffer uninsurance in large part because the children are more likely to be covered by Medicaid and SCHIP programs in the United States. Those who are uninsured tend to be of lower income and lower education and, as the Chairman noticed in her opening remarks, in

working families, but there is not a large difference by health status. There appears to be no like defining characteristic on that dimension.

Among those with longer spells, again we find those who are poorer, lower income, and lower education. This suggests that these are individuals who are in jobs without employer-sponsored insurance. There was also the case that among different ethnic groups, Hispanics are more likely to suffer long spells; and among the age distribution, younger individuals are more likely to be represented there as well.

A moral that comes out of looking at the vast array of statistics that characterize the uninsured and the duration of spells of uninsured is that it is a very multidimensional problem and it will not be simple to target a single characteristic to identify those who would be likely to be uninsured or even uninsured for a great length of time. All of this diversity and dynamics occurs within longer term trends in the top line number, the fraction of individuals without insurance.

We show in the next chart some of the patterns over the past two decades in the level of uninsurance in the population. Out of the 160 million Americans with insurance, about 64 percent receive their insurance through their employer. That is down about 6 percentage points from the beginning of the chart in 1997. If you look, the large move occurred between 1987 and 1993 when there was about a 6 percentage point drop in the total level of employer-sponsored insurance. Since then, we have seen a modest rise and then a reversal during the most recent time period.

The Medicaid pattern in the green bar roughly offsets the trend in employer-sponsored insurance. This suggests that one concern may be that variations in new sources of insurance, such as Medicaid or expansions of other types, may offset existing employer-sponsored insurance or crowd it out to some extent, a topic to which I will return before I close.

The topic of the hearing itself, the dotted red line, is the rise in uninsurance, which is now about 17 percent overall, up about 3 and one-half percentage points. One lesson I think that is easy to draw from that chart is that the uninsured problem is not new; indeed it is a chronic condition in the United States and needs to be revisited in all its forms.

The final chart examines more carefully the link between health insurance premiums and uninsurance. I want to say at the outset that the link between these two is far from simple. One could imagine a situation in which premiums rose in the absence of any change in the underlying benefit from being insured, and in those circumstances it is quite rational for individuals to choose to purchase less insurance, and we might see uninsurance rise.

On the other hand, to the extent that health care costs per se simply go up, the value of insurance rises and one might expect more individuals to choose to purchase insurance and to negotiate with their employers to get coverage. So, there is not an absolute relationship between premiums which may be driven by benefit increases and premiums which are not and the rate of uninsurance.

Nevertheless, a casual inspection of the historical record suggests some relationship between rising health insurance premiums, an

episode in the late eighties and early nineties, and more recently have both coincided with declines in the overall level of the rate of insurance. That may come in roughly two kinds of categories, those which are related to business cycles. We discuss in the testimony the notion that COBRA coverage may also come with not only the opportunity to buy but the obligation to pay a much higher premium in the face of diminished income—that would be difficult—but also for longer term movements in the crowd-out between the enhanced Medicaid programs and the acquisition of private insurance. Some estimates in the literature suggest that expansions in Medicaid are offset by as much as 10 to 25 percent in reduced private insurance. With that overview of the testimony, I would like to close and be happy to answer your questions.

[The prepared statement of Dr. Holtz-Eakin follows:]

**Statement of Douglas Holtz-Eakin, Ph.D., Director, Congressional Budget Office**

Chairman Johnson and Members of the Subcommittee, I appreciate the opportunity to be here today to discuss the characteristics of people without health insurance and the relationship between health insurance premiums and insurance coverage. Although more than 240 million people in the United States have health insurance today through a variety of private and public sources, millions of others do not; and the percentage of Americans who are uninsured has risen in each of the last two years for which information is available.

In my testimony today, I will discuss some important characteristics of the uninsured population that have received relatively little attention but that have important implications for federal policies to expand insurance coverage. I will also discuss the implications of rising health insurance premiums for insurance coverage rates and the potential costs of federal programs to expand coverage.

**Characteristics of the Uninsured Population**

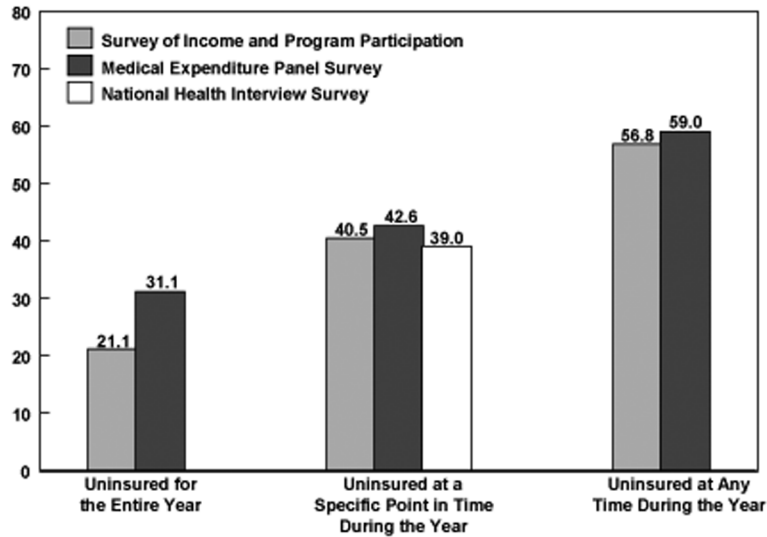
In recent years, it has been frequently stated that about 40 million Americans lack health insurance coverage. That estimate, by itself, presents an incomplete and potentially misleading picture of the uninsured population. The uninsured population is constantly changing as people gain coverage and lose coverage. Furthermore, people vary greatly in the length of time that they remain uninsured. Some people are uninsured for long periods of time, but more are uninsured for shorter periods.

There are several alternative measures of the number of people who lack insurance coverage. One describes those people who do not have coverage for a sustained period (say, one year)—the long-term uninsured. Alternatively, another identifies how many individuals have experienced any spell without insurance during a particular period. Finally, the most commonly used measure (a mixture of those two others) counts the number of individuals without insurance on any particular day or in a certain week. Those different approaches yield different numbers because of the continual movement of people into and out of the uninsured population. The Congressional Budget Office's (CBO's) recent analysis<sup>1</sup> found that in 1998:

- Between 21 million and 31 million people were uninsured all year;
- At any point in time during the year, about 40 million people were uninsured; and
- Nearly 60 million people were uninsured at some point during the year (see Figure 1).

<sup>1</sup> Congressional Budget Office, *How Many People Lack Health Insurance and for How Long?* (May 2003).

**Figure 1. Estimated Number of Nonelderly People Without Health Insurance in 1998**



Source: Congressional Budget Office.

Note: The Survey of Income and Program Participation is conducted by the Census Bureau. The Medical Expenditure Panel Survey is conducted by the Agency for Healthcare Research and Quality. The National Health Interview Survey, which reports only the point-in-time estimate, is sponsored by the Centers for Disease Control and Prevention.

CBO conducted the analysis for 1998 because that was the most recent year for which suitable data were available to construct all three measures. More recent analyses by researchers at the Agency for Healthcare Research and Quality indicate that those three measures of the uninsured remained fairly stable in the subsequent period from 1998 to 2001.<sup>2</sup>

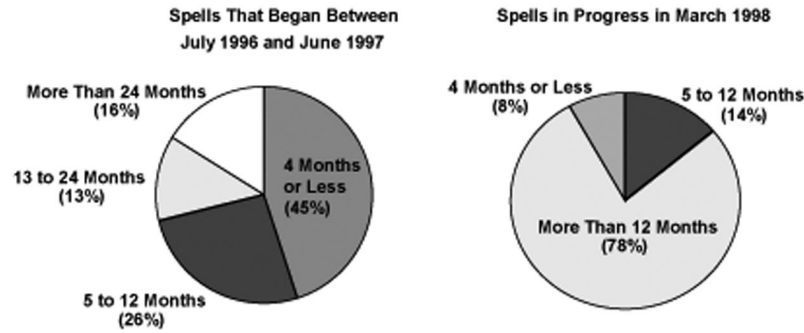
Nearly 30 percent of Americans under age 65 who become uninsured in a given year remain so for more than 12 months, while 45 percent obtain coverage within four months (see Figure 2).<sup>3</sup> Those estimates were obtained by CBO using data from the Census Bureau's Survey of Income and Program Participation for 1996 through 1999. They are very similar to the findings of previous studies that have examined earlier time periods.

Those estimates of the duration of uninsured spells describe the experiences of people who become uninsured in a given year. However, almost 80 percent of the people who lack health insurance at a particular time end up being uninsured for more than 12 months (see Figure 2). Although long uninsured spells occur less frequently than short spells, they are more likely to be under way at any given time.

<sup>2</sup> Agency for Health Care Research and Quality, *The Uninsured in America—1996–2002*, Statistical Brief No. 24, available at [www.ahrq.gov](http://www.ahrq.gov).

<sup>3</sup> Congressional Budget Office, *How Many People Lack Health Insurance Coverage and for How Long?*

**Figure 2. Distribution of Uninsured Spells Among Nonelderly People in a Given Year and at a Given Point in Time, by Duration**



Source: Congressional Budget Office based on data from the first 11 waves of the 1996 panel of the Census Bureau's Survey of Income and Program Participation, which followed respondents over a period of 41 months (from March 1996 through July 1999).

People with less education, those with low income, and Hispanics are more likely than others to be uninsured (see Table 1). They are also somewhat more likely to remain uninsured for long periods. For example, people in families in which no one attended college account for 64 percent of uninsured spells of more than 12 months but only 49 percent of uninsured spells that end within four months (see Table 2). That difference probably reflects, at least in part, the fact that people who did not attend college are less likely than others to have access to employment-based insurance.

**Table 1. Nonelderly People Without Health Insurance in 1998, by Selected Characteristics**

|  | Nonelderly People           |   |                              | Distribution of the Uninsured Population (Percent) |
|--|-----------------------------|---|------------------------------|--|
|  | Characteristic              | Uninsured at Any Time During the Year (Percent) | Uninsured All Year (Percent) |  |
| Age  | Less than 19                | 26.8  | 7.3                          | 24.9   |
|  | 19–24                       | 41.9  | 14.4                         | 13.7   |
|  | 25–34                       | 31.1  | 12.3                         | 21.9   |
|  | 35–44                       | 20.2  | 9.3                          | 19.7   |
|  | 45–54                       | 15.1  | 7.6                          | 12.6   |
|  | 55–64                       | 14  | 6.7                          | 7.2  |
| Race/Ethnicity   | White, Non-Hispanic         | 18.4  | 6.3                          | 48.4   |
|  | Black, Non-Hispanic         | 33.4  | 10.7                         | 15.3   |
|  | Hispanic                    | 47.4  | 22.5                         | 30.8   |
|  | Other                       | 31.1  | 10.9                         | 5.5  |
| Family Income Relative to the Poverty Level <sup>a</sup> | Less than 200 percent       | 47.9  | 19.5                         | 74.9   |
|  | 200 percent to 399 percent  | 17.4  | 5.3                          | 19.8   |
|  | 400 percent or more         | 6   | 1.6                          | 5.3  |
| Education <sup>a, b</sup>                                | No high school diploma      | 50.4  | 24.6                         | 28.4   |
|  | High school graduate        | 33.1  | 12.7                         | 36.4   |
|  | Some college course work    | 22.1  | 7.3                          | 26.6   |
|  | Bachelor's degree or higher | 9.9   | 2.6                          | 8.7  |

**Table 1. Nonelderly People Without Health Insurance in 1998, by Selected Characteristics—Continued**

|   | Nonelderly People                      |   |                              | Distribution of the Uninsured Population (Percent) |
|---|--|---|------------------------------|--|
|   | Characteristic                         | Uninsured at Any Time During the Year (Percent) | Uninsured All Year (Percent) |  |
| Family Employment Status <sup>a</sup>       | At least one full-time worker all year | 15  | 5.9                          | 42.9   |
|   | Part-time or part-year work only       | 46.1  | 16.1                         | 46.6   |
|   | No work                                | 32.8  | 13.1                         | 10.6   |
| Health Status <sup>c</sup>                  | Excellent                              | 23.7  | 8.9                          | 28.8   |
|   | Very good                              | 25.1  | 9.3                          | 32.8   |
|   | Good                                   | 24.6  | 9.1                          | 24.5   |
|   | Fair                                   | 25.1  | 8.7                          | 8.9  |
|   | Poor                                   | 25.3  | 10.3                         | 5.1  |
| Memorandum:<br>Total Non-elderly Population |  | 24.5  | 9.1                          | 100  |

Source: Congressional Budget Office based on an analysis of data from the 1996 panel of the Survey of Income and Program Participation.

<sup>a</sup>For family-level variables, families are defined as health insurance eligibility units, which are composed of individuals who could be covered as a family under most private health insurance plans.

<sup>b</sup>Education measures the highest education level among the adults in the family.

<sup>c</sup>Information on health status was collected only for survey respondents who were at least 15 years of age.

**Table 2. Comparison of the Characteristics of Nonelderly People with Short Uninsured Spells and Long Uninsured Spells**

|   | Characteristic              | Duration of Uninsured Spell   |                               |
|---|-----------------------------|-------------------------------|-------------------------------|
|   |                             | Four Months or Less (Percent) | More Than 12 Months (Percent) |
| Total   |                             | 100                           | 100                           |
| Age <sup>a</sup>  | Children                    | 47.3                          | 37.5                          |
|   | Adults                      | 52.7                          | 62.5                          |
| Race/Ethnicity  | White, Non-Hispanic         | 56.7                          | 48.8                          |
|   | Black, Non-Hispanic         | 19.7                          | 18.2                          |
|   | Hispanic                    | 18.4                          | 27.6                          |
|   | Other                       | 5.2                           | 5.4                           |
| Family Income Relative to the Poverty Level <sup>b, c</sup> | Less than 200 percent       | 61.6                          | 77                            |
|   | 200 percent to 399 percent  | 26.7                          | 21                            |
|   | 400 percent or more         | 11.7                          | 7                             |
| Education <sup>a, c</sup>                                   | No high school diploma      | 17.8                          | 26.6                          |
|   | High school graduate only   | 31                            | 37.6                          |
|   | Some college                | 35.5                          | 26.8                          |
|   | Bachelor's degree or higher | 15.6                          | 9                             |

Adults are somewhat more likely than children to remain uninsured for long periods. The availability of Medicaid coverage may explain some of that discrepancy: coverage is available to many children in low-income families, but the majority of low-income adults are not eligible for the program. In addition, evidence suggests that single adults without children may be less inclined to seek insurance, on aver-

age, than adults with children, which may cause them to experience long spells without insurance.

The vast majority of the uninsured are in working families. Some 43 percent of the people who were uninsured all year in 1998 were in families in which at least one person worked full time all year, and 47 percent were in families in which at least one person worked part time or for a portion of the year (see Table 1, column 3). Studies have found that over three-quarters of uninsured workers are not offered insurance by their employer.<sup>4</sup> Low-wage workers are less likely to be offered insurance by their employer and are less likely to accept it if it is offered.

Medicaid is an important source of coverage for children and parents in low-income families, the disabled, and the low-income elderly. However, the number of people who report in population surveys that they have Medicaid coverage is smaller than the number indicated by the program's administrative data. Survey estimates could therefore overstate the number of people who are uninsured. But some evidence, albeit limited, indicates that many of the Medicaid enrollees who do not report being covered by Medicaid mistakenly report another type of coverage, so the bias in estimates of the uninsured may be small.

About half of all uninsured children in 2002 were eligible for Medicaid or the State Children's Health Insurance Program (SCHIP), according to one study.<sup>5</sup> For uninsured people who are eligible but not enrolled, Medicaid provides a form of conditional coverage. Such people can apply for Medicaid at the time that they obtain care and then receive retroactive coverage for their expenses.<sup>6</sup> Because of that provision, some policymakers view those people as insured. Others view them as uninsured because they may not realize that they are eligible for Medicaid and therefore may delay or avoid seeking medical care.

### Trends in Insurance Coverage

The vast majority of nonelderly Americans who have health insurance are covered through their own or a family member's employer. According to the Census Bureau's Current Population Survey (CPS), 161 million nonelderly Americans (or 64 percent of the nonelderly population) had employment-based insurance in 2002.<sup>7</sup>

A smaller proportion of Americans have employment-based insurance today than in 1987 (see Figure 3).<sup>8</sup> The decline in coverage occurred primarily from 1987 to 1993, when the share of the nonelderly population with employment-based coverage fell by nearly 6 percentage points. From 1993 to 2000, the percentage with employment-based coverage stabilized and then increased, before falling in 2001 and 2002. The percentage with employment-based coverage in 2002 stood at about the same level as in 1993.

The percentage of nonelderly Americans without health insurance coverage rose gradually during most of the period from 1987 to 2002, although it fell in 1999 and 2000 (see Figure 3). The uninsurance rate did not increase by as much as employment-based coverage fell because of offsetting changes in the percentage of people who were covered by Medicaid and SCHIP. The share of the nonelderly population that was covered by private nongroup insurance remained relatively stable at about 7 percent. In 2002, about 17 percent of the nonelderly population was uninsured—about 3.5 percentage points higher than in 1987.

<sup>4</sup>See, for example, Bowen Garrett, Len M. Nichols, and Emily K. Greenman, *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* (Washington, D.C.: Urban Institute, 2001).

<sup>5</sup>Genevieve Kenney, Jennifer Haley, and Alexandra Tebay, "Children's Insurance Coverage and Service Use Improve," *Snapshots of America's Families*, vol. 3, no. 1 (Washington, D.C.: Urban Institute, July 2003).

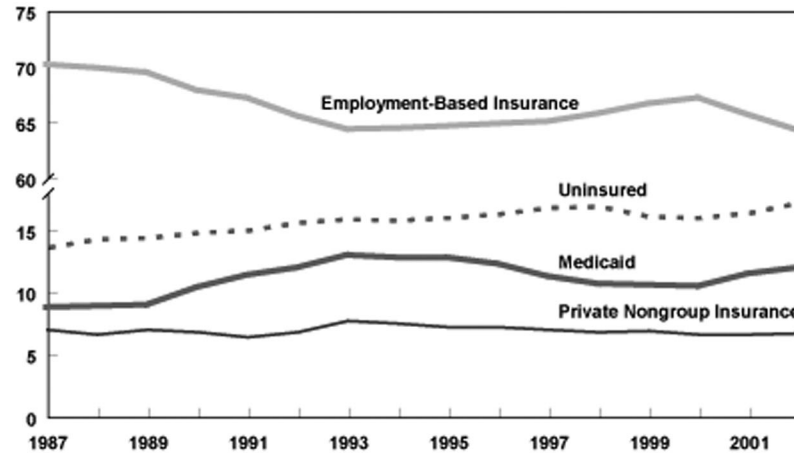
<sup>6</sup>In principle, that provision also applies to SCHIP. However, seven states have placed caps on their enrollments in SCHIP because of budget shortfalls. See Vernon K. Smith and David M. Rousseau, "SCHIP Program Enrollment: June 2003 Update," Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, December 2003).

<sup>7</sup>Researchers disagree about how the CPS estimates of the insured and uninsured should be interpreted. Like many health care analysts, CBO believes that those estimates provide a close approximation of the numbers at a specific point in time. See Congressional Budget Office, *How Many People Lack Health Insurance and for How Long?*

<sup>8</sup>The CPS estimates for 1987 to 2002 have been adjusted to account for changes that were made in the survey design during that period. The estimates are from Paul Fronstin, *Sources of Health Insurance Coverage and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*, Issue Brief No. 264 (Washington, D.C.: Employee Benefit Research Institute, December 2003).



**Figure 3. Percentage of Nonelderly Americans With Employment-Based Health Insurance, Medicaid, and Private Nongroup Insurance and Those Without Insurance, 1987 to 2002**

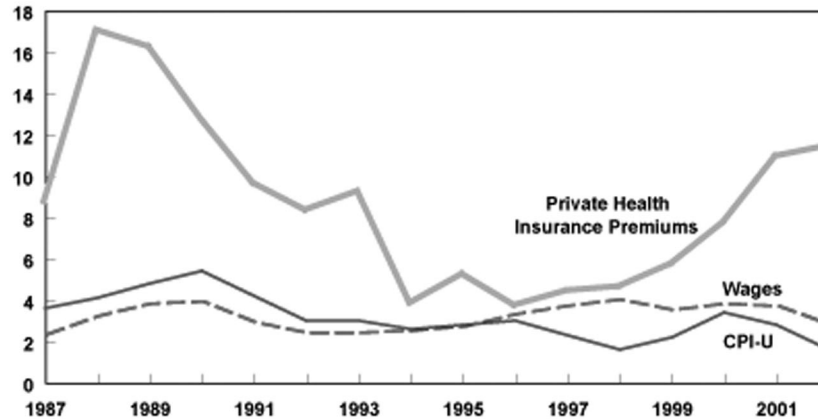


#### **Health Insurance Premiums and Insurance Coverage**

Rapidly rising health insurance premiums are a source of concern first because they are likely to reduce the percentage of people who have health insurance. They also increase the amount of federal subsidy that must be extended to individuals or firms to achieve a specified reduction in the number of people who are uninsured, and the associated growth in health care spending raises the cost of expanding public programs such as Medicaid and SCHIP.

Just how much of the change in insurance coverage rates that has occurred over the past 15 years results from changes in premiums, changes in unemployment rates, and other factors is unknown. But in the two periods in which employment-based coverage dropped (from 1987 to 1993 and from 2000 to the present), health insurance premiums rose rapidly. Private health insurance premiums grew much more rapidly than wages and the prices of other goods and services from 1987 to 1993 and then grew at a more moderate pace until accelerating again in 1999 (see Figure 4). Thus, employment-based coverage rates fell during periods of rapidly rising premiums and stabilized (and even increased) when the growth of premiums slowed. Those simple correlations suggest that rising premiums contributed to the decline in coverage. Other factors, such as cyclical changes in employment, changes in the characteristics of the health plans offered, expansions in public coverage, and demographic changes probably also contributed.

**Figure 4. Annual Percentage Change in Private Health Insurance Premiums, Wages, and the Consumer Price Index, 1987 to 2002**



In discussing the effect of increases in premiums on coverage, distinguishing among different causes of such increases is important. Clearly, an increase in premiums having nothing to do with the quality of the insurance benefit (a tax on premiums, for example) would lead to a reduction in the number of people with health insurance since the price increase would lead some people to drop their coverage. However, the growth in health care spending that has driven the increase in premiums in recent decades has been largely caused by the advancing capabilities of modern medicine. Increases in premiums therefore have reflected, at least in part, changes in the product itself, leaving the effect of premiums on decisions to purchase coverage less clear-cut.

Determining how increases in premiums affect insurance coverage rates is also complicated by the fact that a general upward trend in the cost of medical services can make insurance more appealing, because covering potentially costly medical needs without insurance is more difficult. Although that argument applies to many individuals, others—particularly those with limited financial resources—are more likely to drop coverage when faced with rising premiums and to then rely on care furnished by safety net providers such as community health centers, local health departments, and public hospitals.<sup>9</sup>

The rapid growth in premiums from 1987 to 1993 may have contributed to the reported decline in the rates at which employees take up the offer of employment-based coverage. According to one study, the reduction in the insurance coverage rate among workers from 1979 to 1997 resulted from two factors: a decline in the rate at which full-time workers accepted an offer of insurance from their employer and a decrease in the proportion of part-time and new full-time workers who were eligible for the insurance that their employer offered.<sup>10</sup> There was no decline in the proportion of workers whose employer offered insurance.

As noted, increasing unemployment rates, too, reduce insurance coverage, because losing a job sometimes puts a worker's employment-based health insurance at risk. In a recent analysis, CBO found that health insurance coverage rates declined significantly among people who received unemployment insurance (UI) benefits for at least four consecutive months in 2001 or early 2002.<sup>11</sup> Some 82 percent of such workers had health insurance coverage (from any source) before they began receiving UI benefits, but only 58 percent had coverage by the final month of those benefits.

<sup>9</sup>David M. Cutler, *Employee Costs and the Decline in Health Insurance Coverage*, Working Paper No. 9036 (Cambridge, Mass.: National Bureau of Economic Research, July 2002).

<sup>10</sup>Henry S. Farber and Helen Levy, "Recent Trends in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?" *Journal of Health Economics*, vol. 19, no. 1 (January 2000), pp. 93–119.

<sup>11</sup>Congressional Budget Office, *Family Income of Unemployment Insurance Recipients* (March 2004).

Federal legislation (the Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA) requires firms with 20 or more employees to continue offering health coverage to workers who separate from their firm. However, firms may charge former employees up to 102 percent of the full (group) premiums for that coverage. Therefore, unemployed workers may face a large increase in their out-of-pocket premiums under COBRA. The reduction in coverage estimated for recipients of unemployment insurance probably stems, in part, from many of those people opting not to purchase coverage under that law.

### Policy Implications

Policies aimed at increasing insurance coverage will be more effective if designed in light of the characteristics of the uninsured population. In particular, policy-makers should be mindful of the dynamic nature of the uninsured population as well as the distinction between the short-term and long-term uninsured. For people with short spells of being uninsured, policies might have the goal of filling the temporary gap in coverage or of preventing such a gap from occurring. For people with longer periods without insurance, policies might seek to provide or facilitate an ongoing source of coverage.

An issue that complicates any policy initiative to expand health insurance is the crowding out of existing sources of coverage. "Crowd-out," which results when coverage through a new government policy initiative replaces private coverage that people would have otherwise had, can occur in various ways. Some employees may drop their employment-based coverage if a government program provides health insurance at a lower premium. Or employers may reduce or drop coverage if the demand from their employees lessens because a government program provides an alternative source of coverage. A related issue concerns health insurance tax credits or similar subsidy programs. Some proposals would extend credits or subsidies to people who would have been insured even without them. Through both phenomena, federal aid is extended to people who otherwise would have been insured. As a result, the federal cost per *newly* insured person could be substantially greater than the cost for each person who uses the federal program or who receives the tax credit.

Information on the amount of crowd-out associated with policies to expand insurance coverage comes primarily from analyses of occasions during the late 1980s and early 1990s when states extended Medicaid coverage to pregnant women and children with income above the federal poverty line.<sup>12</sup> According to those analyses, an estimated 10 percent to 25 percent of the people who were enrolled in Medicaid when eligibility expanded would have otherwise been covered by private insurance.<sup>13</sup> The variation in the estimates arises to some extent from the use of different methods in measuring the effect. Such estimates may also vary because of differences in the types of people eligible for the public programs being measured. In particular, crowd-out rates increase as programs extend the level of income that enrollees may have, as the eligible population includes an increasing share of people who have private insurance instead of no insurance.

Finally, incremental reforms probably cannot provide insurance for everyone, and attempting to achieve 100 percent coverage would be very expensive. As an alternative, policymakers could consider policies aimed at expanding insurance coverage in conjunction with policies to strengthen the system through which the uninsured receive medical care—for example, through increased funding of community health centers and public hospitals.

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Chairman JOHNSON. Thank you. Thank you very much. On this issue of crowd-out, which is perhaps the most difficult aspect of doing something about the uninsured, States have done different things in terms of coverage. Have you done any work on States that have tried universal coverage to see what the crowd-out impact, particularly on small business, was?

<sup>12</sup>No estimates of the crowd-out associated with tax inducements for insurance coverage are available.

<sup>13</sup>For a review of the literature on crowd-out, see *Understanding the Dynamics of "Crowd-out": Defining Public/Private Coverage Substitution for Policy and Research* (report prepared by the Academy for Health Services Research and Health Policy under The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization Program, June 2001).

Dr. HOLTZ-EAKIN. We haven't done any work at CBO on that particular issue. We have relied on our surveys of the literature in looking at, particularly Medicaid expansions which have given the best body of evidence, to look at impacts with respect to different income levels as the expansions took place at different parts of the income distribution. We can go back and look at the literature and see if it gives us more evidence at the State level evidence and will be happy to work with you to get that back to you.

Chairman JOHNSON. I should think it would be interesting to look at TennCare in Tennessee and see whether the change in the public coverage affected employer-provided insurance, particularly for small businesses. What were the other ramifications?

Dr. HOLTZ-EAKIN. We can go back and look at the Tennessee experience. Most of the academic literature tries to aggregate many different State experiences into a summary statistic on crowd-out without itemizing State-by-State experiences but it is certainly within the data.

Chairman JOHNSON. I don't know whether you can look at whether those States have taken up all the options under Medicaid, so they cover a much larger population, much higher up the income ladder, what the sort of comparison is between willingness to provide insurance in the small business sector in States with low Medicaid definitions versus States with high Medicaid definitions. I mention that because during the Medicare debate, one of the things that surprised me absolutely the most and one of the reasons I think the benefits in that bill are being grossly underestimated is that 38 States define Medicaid eligibility as 75 percent of the Federal poverty level.

So, for us to cover people basically up to 150 percent does make a huge difference for many seniors throughout the country. If that is what States are doing, then in those States, the small businesses may be finding a way to participate in their employees' health care at a higher rate than, for example, in a State like Connecticut that has generous Medicaid coverage. So, if there is any way we could look at those two things I would appreciate it. I have two specific questions and then I will turn it over to Mr. Stark. In your charts and your testimony, you mentioned that there is somewhere between 21 million and 31 million, approximately, uninsured all year. That is a huge swing. That is a 50 percent swing. Why can't you do better than that?

Dr. HOLTZ-EAKIN. The range of estimates comes from looking at different data sources for information about the uninsured. To track completely a spell of uninsurance requires the kind of data that follows individuals through time. Such data sets are relatively rare. To the extent that they ask good questions about the nature of individuals' health insurance coverage is even rarer.

So, we have a restricted amount of data, quite frankly, that are available to answer this question. I guess it is in the eye of the beholder. From the point of view of someone who has looked at data on many problems in economics for a long period of time, I was less unhappy with that swing than you might have been. I think the key message is that out of the whole population of the uninsured, there is a smaller subset which is uninsured for a sustained period of time, and if one wanted to target that audience more carefully

it might be useful to peel back more layers, look at those individuals who perhaps had not declined employer coverage. If they declined employer coverage, it is hard to argue that they were uninsured involuntarily. You could look at the degree to which they might be eligible for Medicaid and not take it up.

Chairman JOHNSON. Two things. First of all, I think it would be very useful to know more about the difference between 21 million and 31 million because what you are really saying is either half of the uninsured are uninsured for 12 months or more or three-quarters. So, I would like to know more about that figure.

Dr. HOLTZ-EAKIN. We can certainly provide that.

Chairman JOHNSON. I would appreciate that.

[The information was not received at the time of printing]

Chairman JOHNSON. Then in your other chart, about spells in progress and spells that began. On one chart you have 45 percent uninsured for less than 4 months, 26 percent for 5 to 12 months, and about 30 percent for more than 12 months. So, about 30 percent for more than a year. Then, in the chart beside it, 78 percent were uninsured for more than 12 months. You explained that with some man-in-the-street question. I didn't get that. If only 30 percent are actually uninsured for more than 12 months, why do 78 percent think they are?

Dr. HOLTZ-EAKIN. It represents the difference between watching someone progress through an entire spell, from beginning to end and seeing how long it is, versus walking out and finding people perhaps in the middle of a spell of uninsurance. There are a smaller fraction, 30 percent, who have very long spells, so you are more likely to run into that person when you survey. As a result, in the right panel, what you see is the answer to the question when we find somebody in the survey then and say are you uninsured, they say yes, they are more likely to be the kind of person who has a long spell because they are more likely to be found in such a survey.

Chairman JOHNSON. Do we ask them how long have you been uninsured or do we ask them how long do you think you will be uninsured?

Dr. HOLTZ-EAKIN. We ask the first question. The latter we can only track by following them for a long period of time. The data are fairly limited.

Chairman JOHNSON. It seems to me that the former number is the one that we as policymakers should be more concerned with. That is the number who actually are uninsured for more than a year. Is that the correct interpretation?

Dr. HOLTZ-EAKIN. Yes.

Chairman JOHNSON. Thank you very much, Dr. Holtz-Eakin. Mr. Stark.

Mr. STARK. I gather that this is sort of like labor statistics, and are you talking to the people at home or are you talking to the employers to get different employment figures? I don't think it makes a whole hell of a lot of difference. You still only had 21,000 jobs last month and when you need 300,000 or 400,000 jobs a month, we aren't doing very well, as we are not in taking care of people who aren't insured. I guess the real question is, How many people

get sick when they don't have insurance? I don't know as we know that, do we?

Dr. HOLTZ-EAKIN. The onset of—

Mr. STARK. The onset of an expensive medical encounter. How many people have a heart attack or get diagnosed with diabetes? I don't think we know that. Maybe somebody does, but I don't know as we know. That is the key. If somebody makes it through the year, they are home free, and then they get insurance next year. Where they are going to get it, I don't know. The other thing that I don't believe you define, or anybody else that I know of, is what do you consider as insured. If they have the American Family Life Assurance Company (AFLAC), they get a hundred bucks a day if they get sick because they've got some kind of a hospital policy. Is that insured?

Dr. HOLTZ-EAKIN. In the longer paper that underlies this testimony, the data sources have different classifications. Basically they include employer-sponsored insurance. Not all the details about the policy are available, but these are standard insurance measures.

Mr. STARK. At the low end of the scale with some of the associated health plans, as we have been reading in the press lately about these plans that have cropped up that are phony. People think they have bought health insurance and the insurance company has gone south. We don't have, outside of, say, Medicare, a definition—maybe we do in the Federal Employee Health Benefit Plan (FEHBP). I don't know as the benefits are—if there is a minimum level of benefits there—but we really don't have a definition as to what is, quote, “insured,” do we?

Dr. HOLTZ-EAKIN. The definitions will differ by the survey. It is often self-reported.

Mr. STARK. Particularly if somebody is on the margin, if they have high blood pressure or a host of things where they have been excluded as a preexisting condition, they are really not insured for the things they need most. I don't know how I could define that in a way that a scientific researcher could use it. I do think that with the vast difference in benefits and what is covered and what isn't, we would have a better understanding of how well we are dealing with this problem if we could define where we put somebody in the winner category. We just don't take them and give them some kind of schlocky insurance company that may not pay benefits, may not pay hospital benefits, may not have mental health.

We say, look, here is a standard of what a person ought to have; and then the question is, if they have a holdover when—as you say in your testimony—they move from job to job, but really do you count the time between when the new insurance goes into effect, which often is 60 days, 90 days? Yes, they may be insured, but the benefits don't start if you get sick in that trial period, and there may be preexisting conditions which have been precluded, all of which I think makes no difference. I am just suggesting that we could argue all day whether there are 30 million or 40 million, and nobody has brought up children. I keep hearing the number 12 million. What would you say is the number of children? How would you define that?

Dr. HOLTZ-EAKIN. Depending on the definition, we show in Table 1 some of the fraction of those individuals less than 19 who

are uninsured at any point during the year. It is about a quarter in our data.

Mr. STARK. About 25 percent of the uninsured are kids?

Dr. HOLTZ-EAKIN. Yes. Of the kids are uninsured at some point during the year.

Mr. STARK. Again, I think this is all very interesting, but what does General Accounting Office (GAO) suggest we do to get all these people insured?

Dr. HOLTZ-EAKIN. I am not familiar with what the GAO folks would suggest, sir.

Mr. STARK. Okay. What do you think we should do? You are studying this. You say you think we have trouble affording it. What about the social costs? General Motors tells us they lose \$1,300 by making a car here as opposed to making it in Canada. That may be an incentive to not have jobs here or there. In your opinion, is that something we should take into account when we think about Federal costs of insuring everybody?

Dr. HOLTZ-EAKIN. On the job location, I think the key thing to focus on is not any particular part of the benefit package, but labor costs in any location here versus Canada. I am not familiar with the particular number you quoted. Certainly if you want to look at the decision to locate a facility or a job in one place or another, the typical standard is unit labor cost relative to the productivity of labor, not a benefit in isolation.

The broader question, the intent of my remarks was not to tee up specific policy solutions but to identify the fact that there are many different features to the issue of uninsurance. There is the time series pattern of the total uninsurance, and then there is the fact that within the population, there appear to be different kinds of experience with spells of uninsurance. It wasn't meant to offer specific solutions but to frame up the issues.

Mr. STARK. So, you don't have a suggestion for us?

Chairman JOHNSON. Mr. Stark, we actually didn't ask them to come to talk about that. They are not prepared for that.

Mr. STARK. As a person who has a lot of knowledge about this, as an economist approach to what it will cost, I think you did say it would be expensive, didn't you?

Chairman JOHNSON. Let me go on to Mr. Crane.

Mr. STARK. Sure.

Mr. CRANE. Thank you, Madam Chairman, and thank you, Dr. Holtz-Eakin, for coming today. As you know, H.R. 1, the Medicare prescription Drug and Modernization Act, included language that created Health Savings Accounts (HSAs) for all Americans. Do you recall CBO's estimation for the number of individuals who would purchase a new HSA based on the new law?

Dr. HOLTZ-EAKIN. I don't know the number of individuals who would purchase them. I know the Joint Committee on Taxation scored the budget costs of it. We could certainly discuss with them the underlying mechanics of the estimate.

Mr. CRANE. According to the last Department of the Treasury report, 73 percent of people who had a medical savings account were previously uninsured, is that correct?

Dr. HOLTZ-EAKIN. I am not familiar with that number again. We can work with you to make sure that that is right.

Mr. CRANE. One of the arguments against HSAs is that this type of savings account drives people out of employer-sponsored health care coverage, but based on the Treasury Department's report, it seems that most people were not driven out of the system. They had no insurance at all. Based on factual data, it seems that these types of accounts are not undermining the employer-based health care system. Would you agree?

Dr. HOLTZ-EAKIN. I think it is important to look at the evidence. Certainly if you look at the incentives in an HSA, they will differ on both the dimension for insurance and the incentives for efficient use of health care. For some individuals who are already purchasing insurance to get a tax subsidy and take on the HSA is clearly to their advantage, it doesn't change insurance coverage at all. For other individuals who do not have insurance, there is an obvious incentive, lowering the cost. It will be an empirical issue as to which of those things dominates on the insurance front.

Mr. CRANE. You stated in your testimony that the vast majority of the uninsured are in working families and that over three-quarters of uninsured workers are not offered insurance by their employer and that low-income workers are less likely to be offered insurance by their employer and are less likely to accept it if it is offered. It seems to me that if we are going to find a way to help uninsured individuals, the first place we need to start is to make health care more affordable for individuals and small businesses. Would you agree?

Dr. HOLTZ-EAKIN. It certainly appears that the employer-sponsored part of this is an important part of it, especially the transitory spells of uninsurance.

Mr. CRANE. Thank you.

Chairman JOHNSON. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chairman. There is a fascinating article in today's Washington Post entitled "Rising Costs of Health Care in the U.S. Give Other Developed Countries an Edge in Keeping Jobs." Some guy named Jim Stanford, an economist with the Canadian Auto Workers, said employers who operate in either country, meaning Canada or the United States, can save \$4 an hour per worker by choosing Canada. He says that is a significant differential. It's one of the reasons the Canadian auto industry has done a lot better.

Officials from Ford Motor, General Motors, and DaimlerChrysler sent out a letter that said the Canadian public health system significantly reduces total labor costs compared to the costs of equivalent private health insurance services purchased by the U.S.-based auto makers. Then, finally, the Vice Chairman of the Ford company said, high health care costs have created a competitive gap that is driving investment decisions away from the United States.

My question to you is the Institute of Medicine did a study last year, a 3-year study on the uninsured and said that the U.S. economy loses between \$65 and \$130 billion each year because we don't have a system of universal coverage. Have you done any kind of look at that at all? Did you look at their study?

Dr. HOLTZ-EAKIN. I read the study briefly. I won't pretend to be intimately familiar with the research underneath it. At CBO we haven't done any estimate of losses of that sort.



Mr. MCDERMOTT. In a country where these things are true about Canada—presumably they are true. I remember that in 1994 we had a lot of people going around beating on their chests and very proudly saying we defeated the Clinton program and that the private sector would take care of it. Is there any evidence whatsoever that you can show me since 1994 that the private sector has done one thing to deal with the measure of uninsurance in this country?

Dr. HOLTZ-EAKIN. The evidence on uninsurance, we have presented in my opening remarks and in our testimony. I guess I would go back to—

Mr. MCDERMOTT. You think since 1994 it has gotten better?

Dr. HOLTZ-EAKIN. In the overall insurance rate, we saw a sharp drop between 1987 and 1993. Then it rose during the nineties and has declined more recently. We are at 64 percent overall in employer-sponsored insurance. I guess I would repeat what I offered to Mr. Stark, which is that, with all due respect to the individuals involved in the auto companies, I am not familiar with their numbers, it is not the full calculation to look only at health care costs in the two countries, especially at the employer level. It is the total cost of labor compensation relative to how productive those workers are that will be the key issue.

If health care costs rose and nothing else changed, certainly that is a competitive disadvantage. The evidence, however, over a long period of time in the United States and elsewhere is that if one part of the benefit package rises, it is usually offset to some extent by another part of the benefit package or wages. So, the total compensation package does not—

Mr. MCDERMOTT. So, workers wind up really worse off because more of their pay goes into their benefit package than it does into their pocket.

Dr. HOLTZ-EAKIN. Obviously they value the benefit. So, it is a mix that offsets one value of compensation with another.

Mr. MCDERMOTT. Are you testifying that from your research, that there is really no problem, then, with the health insurance? Eight years in a row of double-digit inflation. The private sector was going to take care of that, they told us in 1994, because they were scared that the—that the health providers would be scared and the insurers could get a better deal. We have had 8 years of double-digit inflation. What is happening here? Why does it continue to go up? We leave more and more people by the side of the road, even if for 3 or 4 months.

If you are uninsured and you get sick, it doesn't make any difference whether you haven't been insured for a week or 12 months and 25 days. It really is a question of what you do. Where is the control that is supposed to come out of the private sector? I am a free enterpriser. I believe in free enterprise, but I don't see them functioning at all. They put down the government system. So, where is the evidence that they control costs?

Dr. HOLTZ-EAKIN. I think the underlying question with the rising cost of health care in the United States, not insurance per se, starts with care. Then I think there is broad consensus that it is associated with technology adoption and the enhancement of technologies in the medical sector. They have not in the United States

and elsewhere proven to be cost savers. The question is whether the difference in quality is worth the money.

Mr. MCDERMOTT. All this technology has not proven to be a cost saver. Why does the health care industry continue to do it then? Why does the insurance pay for it? If it doesn't save costs, why do they pay for it?

Dr. HOLTZ-EAKIN. As an economist, I would answer that if quality is higher, you would be willing to pay more for something. What remains the outstanding question is whether we are getting quality per dollar with the technology enhancements. That is the question for the United States in looking at the efficient provision of health care. Insurance is layered on top of that to spread the financial risk of providing that care. The underlying issue of the rising cost of health care is one in which it may be the case that quality is rising and as this Nation becomes older and wealthier it may choose to buy more health care. It may also be the case that at the margin, some of these enhancements do not provide the quality enough to offset their dollar cost. That is the key issue I think in terms of the cost.

Mr. MCDERMOTT. Did you do any cost-benefit analysis at all? Did you look at the cost-benefit analysis at all in terms of our system versus any of these other systems?

Dr. HOLTZ-EAKIN. We don't have a study on that. One of the questions that would be difficult is measuring benefits. As you can imagine just by introspection, valuing the benefits of additional medical technology is a very difficult task, both in economic and social terms.

Mr. MCDERMOTT. I yield back the balance of my time. We don't need another study, Madam Chairman.

Chairman JOHNSON. I don't know that I have ever seen a study that I thought was useful on that. At the time this issue first came up in the eighties, we had more computerized axial tomography (CAT) scanners in Connecticut than all of Canada. That says a lot about access to quality care. I don't know how you would deal with that in a comparative analysis of health care costs. That has been one of the difficulties.

I just wanted to put on the record one issue that I talked with you about that you did not mention in your testimony so I didn't talk—bring it up earlier. You don't mention the variation in the uninsured geographically. You talk about it demographically and in terms of income and age, but not geographically. I think we need to know that, because these sort of generic fixes end up having an enormous number of ramifications.

For instance, if you go to a policy that provides tax credits, even if they are refundable and they go to 100 percent at certain wages, that will certainly displace a lot of employer-provided plans. There are other problems with it. If we understood the geographic structure of the uninsured population, we would have a lot more levers to pull.

I just want to comment that the Health Resources and Services Administration is handing out grants to community health centers that will do two things, and they are 3-year grants. They will search out the underinsured and the uninsured in their region and bring them into the system and implant electronic technology so

that any place they enter the system, whether it is the hospital, the doctor's office or their community health center, a home health agency, an optometrist, wherever, they can be brought into the system by electronic record so that then wherever they come again, their records will be available. It is a very exciting, big effort. I hope to get some report on where they are on that in some of the older demonstration areas as some portion of the guidance that this Committee will need. If you could talk with Census and search out and see what do we know about the geographic distribution, that would be something of interest to, I think, this Committee. Thank you.

Dr. HOLTZ-EAKIN. Certainly.

Chairman JOHNSON. We now will ask our second panel to come forward. As they are coming forward, I will just introduce them very briefly. Diane Rowland is the executive vice president of the Henry J. Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid and the uninsured. I won't go through her whole biography but she has done a lot of very important work on Medicaid and long-term care issues, cost containment issues and so on.

I am very pleased to have Dr. Rowland with us. Dr. Nichols is from the Center for Studying Health System Change, a non-partisan health policy research organization in Washington. He is an expert on private insurance markets, market-based reforms and the Medicare Program. Dr. Glenn Melnick is the Blue Cross of California Professor of Health Care Finance at the University of southern California and a senior economist and resident consultant at RAND Corporation in Santa Monica. He has focused a lot of time and effort on areas such as pricing of hospital services, health insurance and health care markets. We appreciate him being with us here today. Greg Scandlen is with the Galen Institute and is an expert on financing, insurance regulation, and employee benefits and has written extensively on consumer choice and publishes a weekly newsletter, Consumer Choice Matters.

We welcome you all here today. We thank you for your input and your help as we embark on this effort to take some action on the uninsured. I know it is an old issue as Pete has mentioned. It has been with us for a long time, through Republican Administrations and Democratic Administrations. It is a hard problem, which is one of the reasons we haven't solved it. Also our system has a peculiar way of ultimately providing health care. At this point, it is not only the uninsured, we can't afford for people to be uninsured as a matter of principle, but also the caring system can no longer sustain the costs of nonpayers. Dr. Rowland, if you would proceed.

**STATEMENT OF DIANE ROWLAND, EXECUTIVE DIRECTOR,  
KAISER COMMISSION ON MEDICAID AND THE UNINSURED**

Ms. ROWLAND. Thank you, Madam Chairman and Members of the Committee, for this opportunity to be with you today to discuss the Nation's uninsured problem and population. While surveys differ in their count of the uninsured and the time period without health insurance, all tell us that millions of Americans go without coverage each year, and many for long periods of time. The census data we use to monitor health insurance coverage that gives us in

2002 the number 43 million Americans at any given point without health insurance also helps us to understand how this number changes over time. In 2002, we saw an increase of 2.4 million without insurance over the previous year. The size of our uninsured population, in fact, is comparable to the number of beneficiaries you deal with in other legislation who are Members of the Medicare Program.

While the composition of the uninsured population includes Americans of all ages and incomes, the problem, especially for the long-term uninsured, is particularly focused on low-income families. Health insurance coverage in America is very much a patchwork. Having insurance depends on where you live, where you work, and what you earn. In fact, as you pointed out, Madam Chair, the geographic variations in the rate of insurance coverage are very significant. Those States with large firms and more affluent economies are more likely to have lower rates of uninsurance than those States with large poverty populations, small businesses and especially rural interests.

There are also many misperceptions about our uninsured population. They are, as you said, hardworking families that do not obtain health coverage through their jobs. Eight in ten of the uninsured come from a working family, but I think most important to remember is that for the most part, they are not affluent. Two out of every three come from low-wage families earning less than \$30,000 for a family of three, families hardly able to afford \$9,000 for a family policy on their own, and in most cases families who work for employers that don't offer coverage. In the few cases where the employer offers coverage to these low-income families, their share of the premium, averaging \$2,400 last year for family coverage, is often too high a price to pay when the family budget is extremely limited.

The uninsured, of course, are predominantly adults because our public programs have actually helped to extend coverage to 1 in 4 American children. Today Medicaid and SCHIP provide coverage to over 25 million low-income children and have dropped the uninsured rate among low-income children from a high of 23 percent in 1997 to 14 percent at the beginning of 2003.

Indeed, a success story in our efforts of extending coverage. This drop in the number of children without insurance has helped to counteract the rise in the uninsured as a result of loss of employer-based coverage. I don't believe it is all crowd-outs. For the most part, you have provided coverage through Medicaid and SCHIP to millions of children previously uninsured, not those who were in the employer-based market. However, limited eligibility for parents and restrictions on coverage of childless adults and Medicaid leave over 20 million low-income adults, half of America's uninsured population on any given day, outside of Medicaid's reach. Unfortunately, in today's economy with weak job growth, the number of Americans without health insurance is likely to grow, not shrink.

Rising health insurance costs are compromising employer-based coverage as more and more employers shift increased costs for premiums and additional cost-sharing burdens onto their employees, making coverage ever more unaffordable for the lowest-wage em-

ployees. Meanwhile, State fiscal constraints are putting Medicaid and SCHIP coverage at risk. Fiscal relief in the tax bill really did help stave off deeper cuts and reductions in Medicaid and reductions in eligibility during the last year, but the matching rate increase will expire this June putting the State's fiscal considerations back on the table.

It is hard to see how we will be able to make progress extending coverage to the uninsured or maintaining the coverage Medicaid now provides without a commitment of additional Federal resources. Addressing the uninsured is, as you have said, a national priority. People without health insurance often go without appropriate care and get sicker and die sooner than they should because of it.

Leaving millions uninsured and coverage of millions more at risk in Medicaid is a poor prescription for our Nation's health. So, I look forward to working with the Committee to find ways to secure the coverage we have and extend coverage to the millions of uninsured who need assistance in meeting their health care needs. Thank you, Dr. Nichols.

[The prepared statement of Ms. Rowland follows:]

**Statement of Diane Rowland, Sc.D., Executive Director, Kaiser Commission on Medicaid and the Uninsured**

- Today, over 43 million Americans are without health insurance. The uninsured are predominantly low-income working families—nearly two-thirds (64%) have incomes below 200 percent of the poverty level (or less than \$30,000 per year for a family of three in 2002).
- Eight in ten of the uninsured come from working families but do not obtain coverage in the workplace. Low-wage workers are particularly disadvantaged—they are less likely to be offered coverage through the workplace and unable to afford coverage on their own.
- The rising cost of health insurance is a major problem for both employers and employees; in 2003, the average premium cost was \$3,383 for single coverage and \$9,068 for family coverage. On average, employers contributed 84 percent of premium costs for single and 73 percent for family coverage; however, the employee share remains a substantial burden for many low-wage workers.
- Medicaid helps fill in the gap by providing health insurance coverage with limited cost sharing and comprehensive benefits to 38 million low-income children and parents, the large majority being children. Medicaid's reach for low-income adults, however, is severely limited—income levels for parents in 35 states are below poverty and childless adults are generally excluded from coverage, no matter how poor.
- The recent economic downturn and return of escalating health costs now place health insurance coverage for working families in jeopardy from increased premium costs and loss of employer-sponsored coverage, combined with limits on the availability and scope of Medicaid due to state fiscal constraints. We face the prospect of seeing coverage erode, not expand, for millions of Americans.
- The combination of rising health care costs and state fiscal constraints puts the low-income population relying on Medicaid and SCHIP particularly at risk. Maintaining the gains in public coverage over the last decade, especially for children, may require continuing federal fiscal relief to the states in return for a commitment to maintain coverage.
- Health insurance matters for the millions of Americans who lack coverage—it influences when and whether they get necessary medical care, the financial burdens they face in obtaining care, and, ultimately, their health and health outcomes. Extending coverage to the millions of Americans without health insurance is both an important policy and health objective.

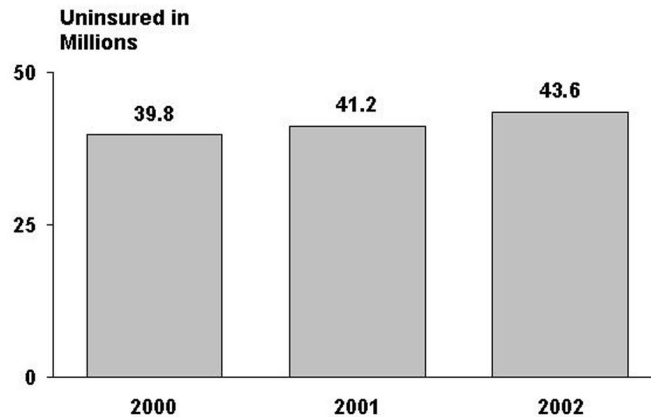
Thank you for the opportunity to offer testimony this afternoon on the nation's growing uninsured population and the consequences of leaving 43 million Americans without health insurance coverage. I am Diane Rowland, Executive Vice President

of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

Health insurance coverage remains one of the nation's most pressing and persistent health care challenges. The most recent data from the Census Bureau show that more than one in every seven Americans—43.6 million adults and children—were without health insurance in 2002. This is not only a large problem, but a growing problem for millions of Americans. From 2001 to 2002, the number of Americans lacking health insurance increased by 2.4 million (Figure 1). Public coverage expansions through Medicaid helped to moderate the growth in the uninsured, most notably by providing coverage to children in low-income families, but were not enough to offset the decline in private coverage. Lack of coverage compromises not only access to care and the health of the uninsured, but also the health and economic well-being of our nation.

Figure 1

### Number of Uninsured Americans, 2000-2002



SOURCE: U.S. Census Bureau, 2003 Current Population Survey. Estimates based on total population.

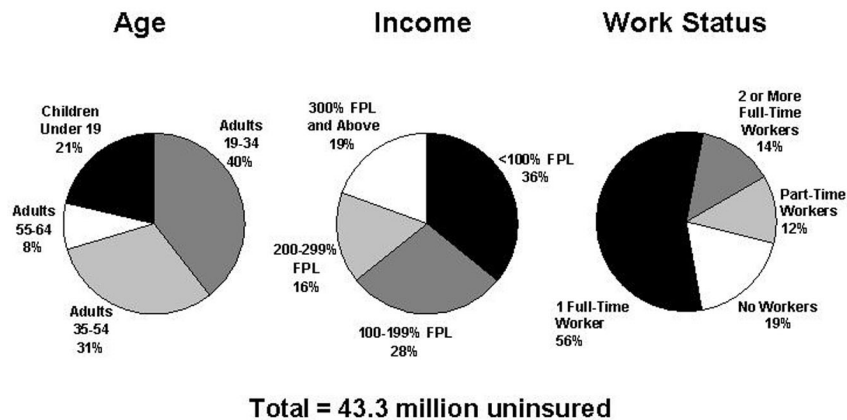
**K A I S E R C O M M I S S I O N O N  
M e d i c a i d a n d t h e U n i n s u r e d**

#### The Uninsured Population

Who are America's 43 million people without health insurance coverage? The uninsured are predominantly adults from low-income working families—three-quarters of the uninsured are between age 18 and 65; two-thirds have incomes below 200 percent of the federal poverty level or \$28,696 for a family of three in 2002; and the majority (eight in 10) come from working families (Figure 2). The complexities of coverage through the workplace combined with gaps in public coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) mean millions of Americans are outside of the reach of health insurance coverage. Health coverage in America is very much a patchwork—having health insurance depends on where you live, where you work, and too often what you earn.

Figure 2

## Characteristics of the Uninsured, 2002



Note: Percentages may not total 100% due to rounding.  
 SOURCE: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

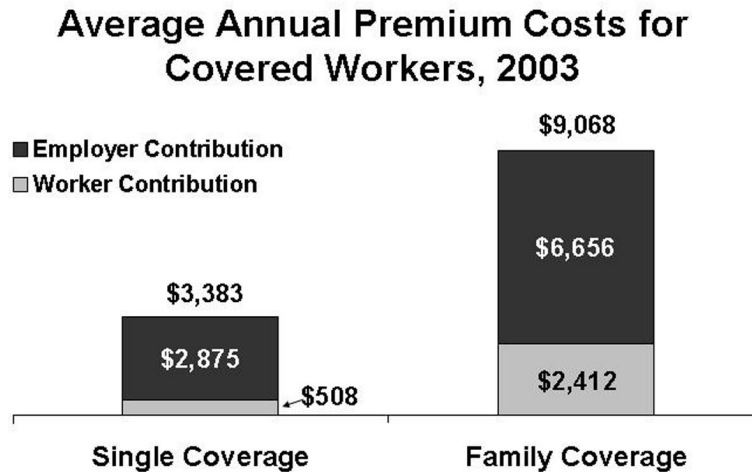
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 Medicaid and the Uninsured**

Two out of three nonelderly Americans receive their health insurance coverage through an employer-sponsored health plan offered through the workplace, but for millions of working families such coverage is either not offered or is financially out of reach. Among the 43 million uninsured, eight in ten come from working families—nearly 70 percent come from families where at least one person works full-time and another 12 percent from families with part-time employment.

Most uninsured workers, and consequently their dependents, are not offered job-based coverage either through their own or a family members job. The likelihood of obtaining coverage through the workplace depends largely on where one works and what one earns. Most large firms offer coverage, but many smaller firms do not. Low-wage workers are often employed in small businesses, particularly in the retail and service industries, where health insurance is not widely offered as a fringe benefit.

The cost of health insurance in the workplace is a substantial financial burden for both the employer and employee, but remains a key fringe benefit, especially in large or unionized firms. When health insurance is offered in the workplace, most employees opt for coverage even though the share of premium they must pay often represents a substantial share of their income. In 2003, the Kaiser/HRET national survey of employers found the average annual premium for employer-sponsored group insurance for a family was \$9,068 with the employer contributing 73 percent of the premium (\$6,656) and the employee contributing 27 percent of the premium or \$2,412 per year (Figure 3). For single individuals, the premiums averaged \$3,383 per year with the employer covering 84 percent of the premium cost (\$2,875 per year).

Figure 3



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SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003.

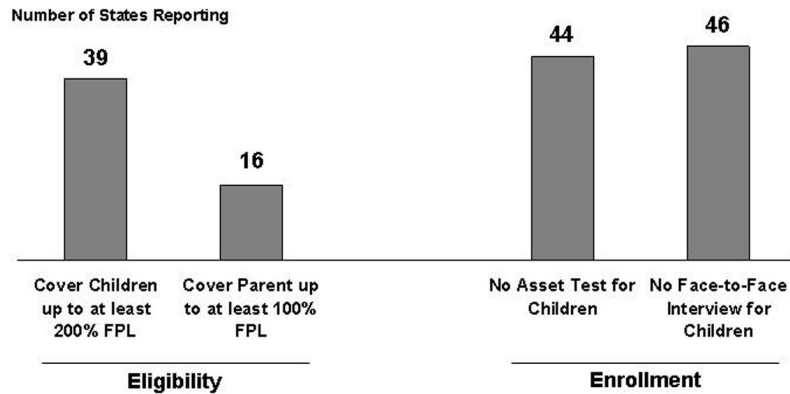
If health insurance coverage is not available through a group policy from an employer, families are hard pressed to be able to find and pay for a policy in the individual insurance market. Most directly purchased policies are expensive and have more limited benefits and more out-of-pocket costs than group coverage plans. Moreover, the cost of these policies is based on age and health risk, and any preexisting health conditions are generally excluded from coverage. For the average low-income family, a \$9,000 family policy in the individual market would consume a third or more of their income, provide only limited protection, and could exclude coverage for any family members with health problems. Most notably, in many states, private plans individually marketed do not provide routine maternity benefits or, if they do, they are offered as a very costly add-on.

Medicaid and SCHIP help fill in the gaps for some of the lowest income people, but this publicly sponsored coverage is directed primarily at children and pregnant women and varies in availability across the states. Most low-income children are eligible for assistance through Medicaid or SCHIP, but in most states parents' eligibility lags far behind that of their children. While eligibility levels for children are at 200 percent of the federal poverty level (\$30,520 for a family of three in 2003) in 39 states, parents' eligibility levels are much lower (Figure 4). A parent working full-time at minimum wage (approximately \$9,300 per year at 35 hours per week) earns too much to be eligible for Medicaid in 19 states (Figure 5). For childless adults, Medicaid funds are not available unless the individual is disabled or lives in one of the few states with a waiver to permit coverage of childless adults. As a result, in 2002, Medicaid provided health insurance coverage to over half of all poor children, and a third of their parents, but only 22 percent of poor childless adults. Over 40 percent of poor adults and a third of near-poor adults were uninsured.



Figure 4

### Improvements in Medicaid and CHIP Coverage, April 2003

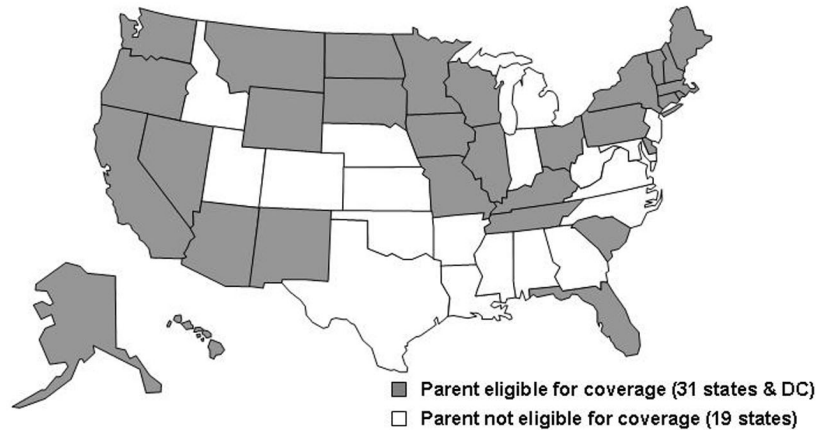


SOURCE: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, July 2003.

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Figure 5

### Medicaid Coverage of Parents Working Full-Time at Minimum Wage, 2003



Note: Assumes parent works 35 hours per week at \$5.15 per hour per month (\$775/month).

SOURCE: KCMU calculations based on data from Cohen Ross, D and L. Cox. 2003.

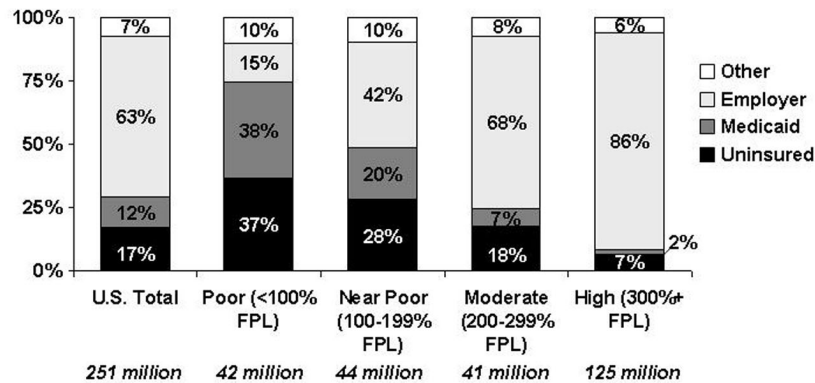
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Low-income individuals are disproportionately represented among the uninsured—nearly two-thirds (64%) of the uninsured come from low-income families earning less than 200 percent of the poverty level and over a third (36%) come from families living below the poverty level. Employer-sponsored coverage is extremely limited for the low-income population; only 15 percent of the poor and 42 percent of the near-poor receive coverage through their employer (Figure 6). Medicaid helps

to offset the lower levels of private insurance for over a third (38%) of the poor and 20 percent of the near-poor, but many parents of low-income children as well as childless adults do not qualify for Medicaid assistance.

Figure 6

### Health Insurance Coverage by Poverty Level, 2002



Notes: The federal poverty level was \$14,348 for a family of three in 2002. Percentages may not total 100% due to rounding.

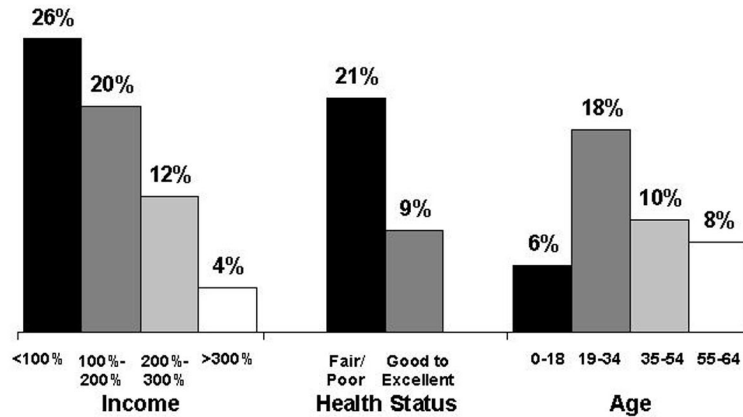
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of the 2003 Current Population Survey.

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The chances of experiencing a long spell without health coverage (12 months or longer) are not equal. Individuals with low incomes and those in fair or poor health status are significantly more likely than others to be uninsured for long periods. Young adults (19–34 years old) are at greater risk of being uninsured for 12 months or longer than other age groups (Figure 7).

Figure 7

## Percent of Population Who Are Uninsured for at Least 12 Months, 2002



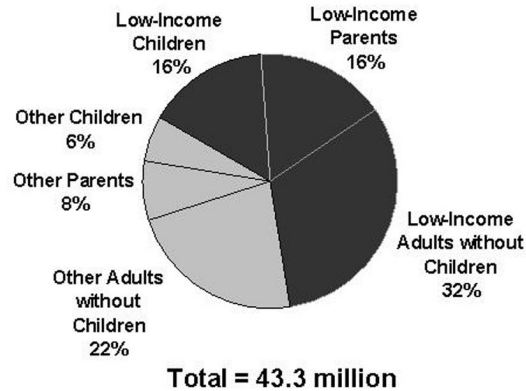
SOURCE: 2002 National Survey of America's Families based on the non-elderly population.

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This confluence of factors relating to the characteristics of the uninsured places low-income adults at the center of the nation's uninsured problem and the group most likely to have long periods without coverage. In 2002, 48 percent of the 43 million uninsured Americans were low-income adults—16 percent parents of low-income children and 32 percent low-income adults without children (Figure 8). Assuring coverage for this group, as well as extending coverage to the parents of the low-income children who are now largely eligible for public coverage, poses the next challenge in coverage expansions. Focusing attention on the lack of coverage for low-income adults and continuing to push for better enrollment of low-income children offers the potential to reach two in three uninsured Americans.

Figure 8

### The Nonelderly Uninsured, by Age and Income Groups, 2002



SOURCE: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

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Medicaid and the Uninsured**

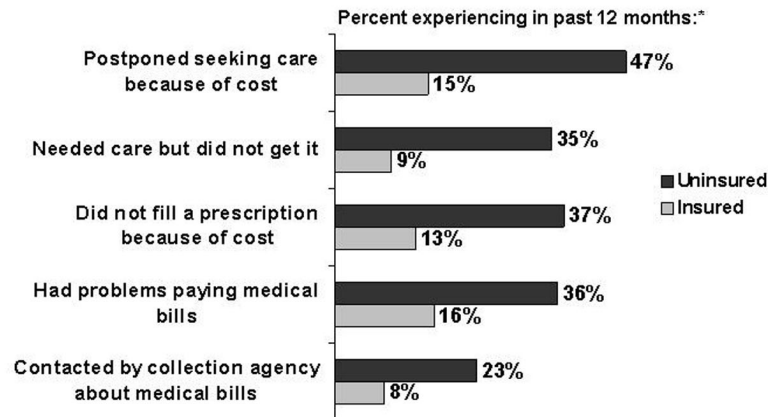
#### THE CONSEQUENCES OF LACK OF INSURANCE

The growing number of uninsured Americans should be of concern to all of us because health insurance makes a difference in how people access the health care system and, ultimately, their health. Leaving a substantial share of our population without health insurance affects not only those who are uninsured, but also the health and economic well-being of our nation.

There is now a substantial body of research documenting disparities in access to care between those with and without insurance. Survey after survey finds the uninsured are more likely than those with insurance to postpone seeking care; forgo needed care; and not get needed prescription medications (Figure 9). Many fear that obtaining care will be too costly. Over a third of the uninsured report needing care and not getting it, and nearly half (47%) say they have postponed seeking care due to cost. Over a third (36%) of the uninsured compared to 16 percent of the insured report having problems paying medical bills, and nearly a quarter (23%) report being contacted by a collection agency about medical bills compared to eight percent of the insured. The uninsured are also less likely to have a regular source of care than the insured, and when they seek care, are more likely to use a health clinic or emergency room. Lack of insurance thus takes a toll on both access to care and the financial well-being of the uninsured.

Figure 9

## Barriers to Health Care by Insurance Status, 2003



Notes: \*Experienced by the respondent or a member of their family.  
Insured includes those covered by public or private health insurance.

Source: Kaiser Family Foundation, *Kaiser 2003 Health Insurance Survey*.

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Moreover, there is a growing body of evidence showing that access and financial well-being are not all that is at stake for the uninsured. There are often serious consequences for those who forgo care. Among the uninsured surveyed, half report a significant loss of time at important life activities, and over half (57%) report a painful temporary disability, while 19 percent report long-term disability as a result. Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than the insured (Figure 10). Uninsured adults are less likely to receive preventive health services such as regular mammograms, clinical breast exams, pap tests, and colorectal screening. They have higher cancer mortality rates, in part, because when cancer is diagnosed late in its progression, the survival chances are greatly reduced. Similarly, uninsured persons with heart disease are less likely to undergo diagnostic and revascularization procedures, less likely to be admitted to hospitals with cardiac services, more likely to delay care for chest pain, and have a 25 percent higher in-hospital mortality.

Figure 10

## The Consequences of Being Uninsured

Research demonstrates that the uninsured:

- use fewer preventive and screening services;
- are sicker when diagnosed;
- receive fewer therapeutic services;
- have poorer health outcomes (higher mortality and disability rates); and
- have lower annual earnings because of poorer health.

SOURCE: Hadley, Jack. "Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* (60:2), June 2003.

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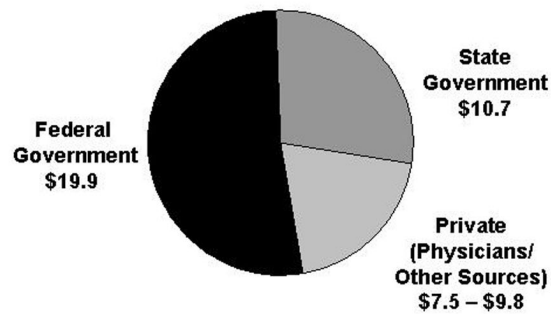
Urban Institute researchers Jack Hadley and John Holahan, drawing from a wide range of studies, conservatively estimate that a reduction in mortality of five to 15 percent could be achieved if the uninsured were to gain continuous health coverage. The Institute of Medicine (IOM) in its analysis of the consequences of lack of insurance estimates that 18,000 Americans die prematurely each year due to the effects of lack of health insurance coverage.

Beyond the direct effects on health, lack of insurance also can compromise earnings of workers and educational attainment of their children. Poor health among adults leads to lower labor force participation, lower work effort in the labor force, and lower earnings. For children, poor health leads to poorer school attendance with both lower school achievement and cognitive development.

These insurance gaps do not solely affect the uninsured themselves, but also affect our communities and society. In 2001, it is estimated that \$35 billion in uncompensated care was provided in the health system with government funding accounting for 75 to 80 percent of all uncompensated care funding (Figure 11). The poorer health of the uninsured adds to the health burden of communities because those without insurance often forgo preventive services, putting them at greater risk of communicable diseases. Communities with high rates of the uninsured face increased pressure on their public health and medical resources.

Figure 11

# **Sources of Funding Available for Uncompensated Care, 2001** (in billions)



**Total = \$38.1 – 40.4 Billion**

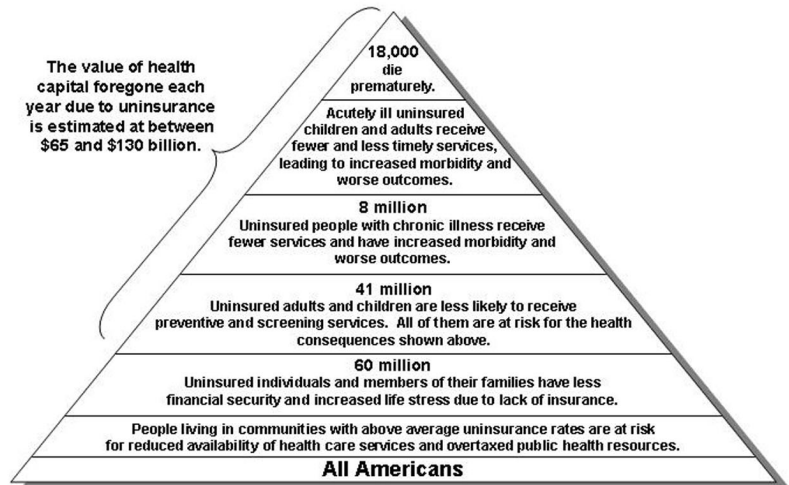
**KAISER COMMISSION ON  
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SOURCE: Hadley and Holahan, February 2003.

A recent IOM report estimates that in the aggregate the diminished health and shorter life spans of Americans who lack insurance is worth between \$65 and \$130 billion for each year spent without health insurance (Figure 12). Although they could not quantify the dollar impact, the IOM committee concluded that public programs such as Social Security Disability Insurance and the criminal justice system are likely to have higher budgetary costs than they would if the U.S. population under age 65 were fully insured. A new study by Hadley and Holahan of the Urban Institute suggests that lack of insurance during late middle age leads to significantly poorer health at age 65 and that continuous coverage in middle age could lead to a \$10 billion per year savings to Medicare and Medicaid.

Figure 12

## The Consequences of Uninsurance



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SOURCE: Institute of Medicine, *Hidden Costs, Value Lost*, June 2003.

### PROSPECTS FOR THE FUTURE

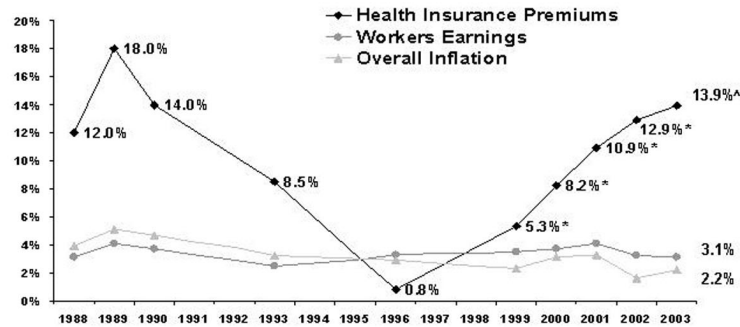
Given the growing consensus that lack of insurance is negatively affecting not only the health of the uninsured, but also the health of the nation, one would expect extending coverage to the uninsured to be a national priority. All indicators point to significant growth in our uninsured population if action is not taken to both broaden and secure coverage.

With the poor economy and rising health care costs, employer-based coverage—the mainstay of our health insurance system—is under increased strain. Health insurance premiums rose nearly 14 percent this year—the third consecutive year of double-digit increases—and a marked contrast to only marginal increases in workers' wages (Figure 13). As a result, workers can expect to pay more for their share of premiums and more out-of-pocket when they obtain care, putting additional stress on limited family budgets. With average family premiums now exceeding \$9,000 per year and the workers' contribution to premiums averaging \$2,400, the cost of coverage is likely to be increasingly unaffordable for many families, especially low-wage workers. However, for most low-wage workers, especially those in small firms, it is a question of availability, not affordability—because the firms they work in do not offer coverage.



Figure 13

## Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four.

\* Estimate is statistically different from the previous year shown at  $p < 0.05$ : 1996-1999, 1999-2000, 2000-2001, 2001-2002.

^ Estimate is statistically different from the previous year shown at  $p < 0.1$ : 2002-2003.

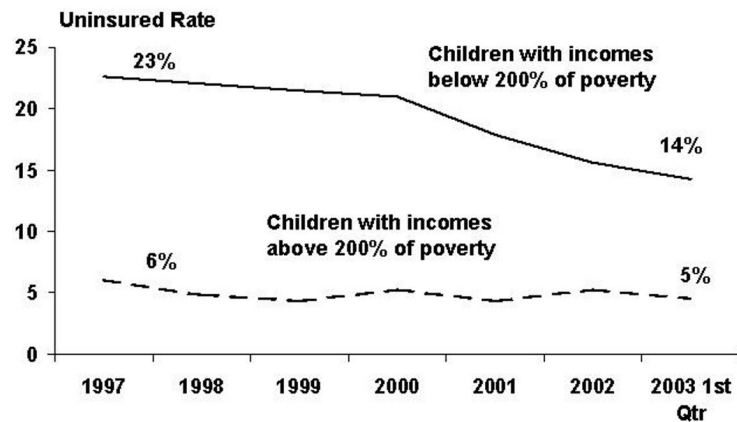
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America: 1988, 1989, 1990.

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In recent years, with SCHIP enactment and Medicaid expansions, states have made notable progress in broadening outreach, simplifying enrollment processes, and extending coverage to more low-income families (Figure 14). Participation in public programs has helped to reduce the number of uninsured children and demonstrated that outreach and streamlined enrollment can improve the reach of public programs. However, the combination of the current fiscal situation of states and the downward turn in our economy are beginning to undo the progress we have seen.

Figure 14

### Trends in the Uninsured Rate of Children, by Income Level

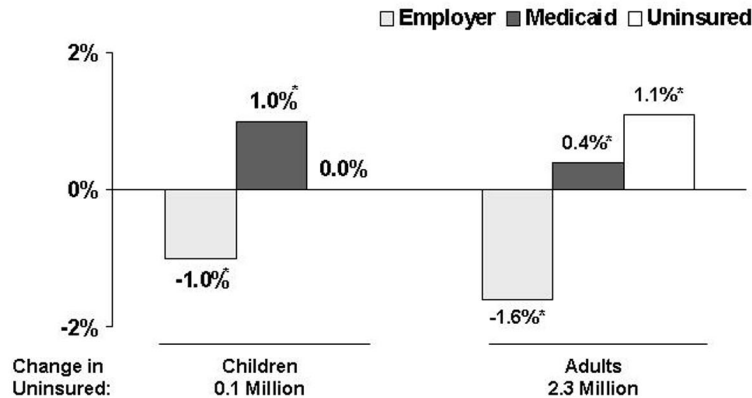


SOURCE: Center on Budget and Policy Priorities analysis of NHIS data. **Kaiser Commission on Medicaid and the Uninsured**

From 2001 to 2002, employer-based health insurance coverage declined for low-income adults and children while Medicaid and SCHIP enrollment increased, muting a sharper climb in the number of uninsured. Most notably, while the number of uninsured adults increased, the number of uninsured children remained stable because public coverage helped fill in the gaps resulting from loss of employer coverage (Figure 15). Recent reports of enrollment freezes in SCHIP programs and reductions in Medicaid coverage are troubling.

Figure 15

## Changes in Health Insurance Coverage, Children vs. Adults, 2001-2002 (Percentage Point Differences)



Notes: \* Statistically significant change between 2001 and 2002 ( $p < .10$ ).  
Medicaid also includes SCHIP, other state programs, Medicare and military-related coverage.  
SOURCE: KCMU and Urban Institute analysis of March Current Population Survey, 2002 and 2003.

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With the recent economic downturn, states have experienced the worst fiscal situation they have faced since the end of World War II. State revenues fell faster and further than anyone predicted, creating substantial shortfalls in state budgets. In 2002, after accounting for the effect of legislative changes, real state revenue collections declined for the first time in a decade—falling 6.8 percent that year followed by a 3.3 percent decline in 2003. Although states predict slight growth for 2004, it is not sufficient to meet rising program costs. Medicaid spending has been increasing as health care costs for both the public and private markets have grown and enrollment in Medicaid has increased, largely as a result of the weak economy and loss of jobs and income. However, even with Medicaid spending pressure, it is the state revenue shortfalls—not Medicaid—that remain the primary cause of the state budget crisis.

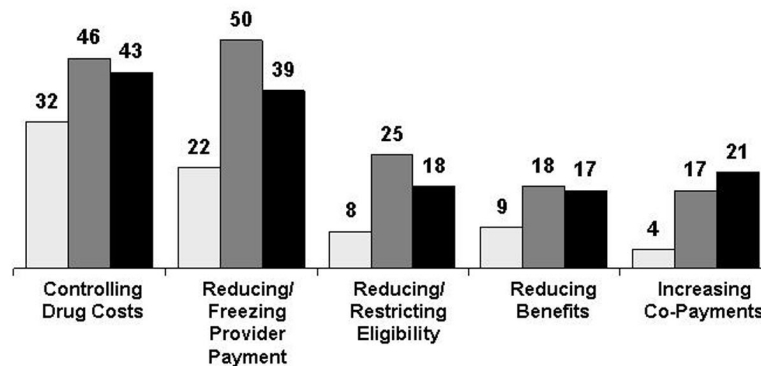
The state revenue falloff is, however, placing enormous pressure on state budgets and endangering states' ability to provide the funds necessary to sustain Medicaid coverage. Turning first to "rainy day" and tobacco settlement funds, states have tried to preserve Medicaid and keep the associated federal dollars in their programs and state economies. But, as the sources of state funds become depleted, states face a daunting challenge in trying to forestall new or deeper cuts in Medicaid spending growth. In the Jobs and Growth Tax Relief Reconciliation Act enacted in May 2003, Congress provided \$20 billion in state fiscal relief, including an estimated \$10 billion through a temporary increase in the federal Medicaid matching rate. This helped states avoid making deeper reductions in their Medicaid spending growth, but this fiscal relief will expire in June of this year. It seems unlikely that states' fiscal conditions will substantially improve by then, so the absence of continued fiscal assistance from the federal government will likely result in additional cutbacks in Medicaid coverage in many states.

Because Medicaid is the second largest item in most state budgets after education, cuts in the program appear inevitable—in the absence of new revenue sources—as states seek to balance their budgets and the fiscal relief expires. Indeed, survey data the Kaiser Commission on Medicaid and the Uninsured released in January indicates that 49 states and the District of Columbia put new Medicaid cost containment strategies in place in fiscal year 2004. This cost containment activity follows two previous years of Medicaid cost containment action in many states (Figure 16).

Figure 16

## States Undertaking Medicaid Cost Containment Strategies FY 2002 - FY 2004

□ Implemented in FY 2002   ■ Implemented in FY 2003   ■ Planned as of January for FY 2004



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September and December 2003.

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States have continued to aggressively pursue a variety of cost containment strategies, including reducing provider payments, placing new limits on prescription drug use and payments, and adopting disease management strategies and trying to better manage high-cost cases. The pressure to reduce Medicaid spending growth further has also led many states to turn to eligibility and benefit reductions as well as increased cost-sharing for beneficiaries, although, reflecting the requirements of the federal fiscal relief, no states have made additional Medicaid eligibility reductions since the fiscal relief took effect last year. Although in many cases these reductions have been targeted fairly narrowly, some states have found it necessary to make deeper reductions, affecting tens of thousands of people.

The fiscal situation in the states jeopardizes not only Medicaid's role as the health insurer of low-income families, but also its broader role as the health and long-term assistance program for the elderly and people with disabilities. Although children account for half of Medicaid's 51 million enrollees, they account for only 18 percent of Medicaid spending. The low-income elderly and disabled population represents a quarter of Medicaid beneficiaries, but 70 percent of all spending because of their greater health needs and dependence on Medicaid for assistance with long-term care. Facing their budget shortfalls, states will find it difficult to achieve painless reductions and understandably are seeking more direct federal assistance, especially with the costs associated with the elderly and disabled who are covered through both Medicare and Medicaid (the dual eligibles) and account for 42 percent of Medicaid spending.

### CONCLUSION

Looking ahead, it is hard to see how we will be able to continue to make progress in expanding coverage to the uninsured or even maintaining the coverage Medicaid now provides. Lack of health coverage is a growing problem for millions of American families. The poor economy combined with rising health care costs make further declines in employer-sponsored coverage likely. The state fiscal situation combined with rising federal deficits complicate any efforts at reform. In the absence of additional federal assistance, the fiscal crisis at the state level is likely to compromise even the ability to maintain coverage through public programs. Although Medicaid has demonstrated success as a source of health coverage for low-income Americans and a critical resource for those with serious health and long-term care needs, that role is now in jeopardy.

Assuring the stability and adequacy of financing to meet the needs of America's most vulnerable and addressing our growing uninsured population ought to be

among the nation's highest priorities. Maintaining the coverage now provided through Medicaid and SCHIP and building on that foundation to extend coverage to more of the low-income uninsured population provides both a tested and cost-effective approach to reducing the number of uninsured Americans. But, like all solutions to the uninsured, this too requires additional resources and given the fiscal straits of the states, undoubtedly means a greater commitment of federal support to address this national problem.

I commend your efforts to highlight the plight of the 43 million Americans without health insurance coverage and to identify options that could help address this growing problem. I look forward to working with you to meet the challenge of making health care coverage a reality for all Americans.

Thank you for the opportunity to testify today. I welcome any questions.

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**STATEMENT OF LEN M. NICHOLS, VICE PRESIDENT, CENTER  
FOR STUDYING HEALTH SYSTEM CHANGE**

Mr. NICHOLS. Madam Chair, Representative Stark, and Members of the Subcommittee, I am honored to testify before you today on a topic of such importance to our Nation. My name is Len Nichols, and I am the vice president of the Center for Studying Health System Change. I am also a participant in the Economic Research Initiative on the Uninsured (ERIU), a project that convened a group of health and labor economists from around the country to sort out what we do and do not know about the uninsured. ERIU recently published a book entitled *Health Policy and the Uninsured*, and my written testimony is organized around 10 myths about the uninsured which are implicitly debunked in different chapters of the book, one of which I coauthored. My remarks today shall highlight four of these myths.

Myth number 3: Coverage is coverage is coverage. As Representative Stark alluded to, the punch line is that head counts in coverage are not enough. Insurance differs in terms of the kind of financial protection it offers, the potential for improvement in health, and the humanity of the treatment when you enter the delivery system. To put it slightly differently, imagine a policy that gave every American as much insurance as \$100 could buy. We would then have zero uninsured, but we wouldn't be very much better off than we are now.

Myth number 4: Health insurance would improve the health of all the uninsured. This is among the more complicated and emotional disputes in health policy analysis. It turns out that standards of proof about causation in this area have not been as high as they should have been. Researchers have come to realize there may be important but unobservable differences in people that make different choices about things like insurance, diet, exercise, and education. If we merely observe what people do without proper research controls, it is hard to be sure what caused and what was merely associated with health outcomes. When appropriate standards of proof have been met, the evidence suggests that health insurance does indeed have positive effects on the health of certain key populations: the poor, the elderly, the truly sick, and children. What has not been proven by this standard is that universal coverage would improve the health of all of the uninsured, and this leads economists to the following three inferences: We cannot say with certainty that more public subsidies for health insurance for

the general population would be the best way to improve health. The second thing, understanding more about the complex relations between health status, health services, health insurance, personal behaviors and information would help us improve our policy advice. Third, there are many reasons to support universal coverage, but the analytic case for the general short-run positive health effects is not the strongest one.

Myth number 9, one of my favorites: Economists don't know anything about why people are uninsured. Sometimes it seems that a normal person might listen to economists argue among themselves and conclude that nothing has ever been satisfactorily proved. That is not the case. This issue is so important, I devote the last two myths to embellishing the point. There are three things most economists actually do believe about the lack of insurance coverage, and this one is key. The single most important reason people are uninsured in this country is they are not willing to pay what it costs to insure themselves. This unwillingness to pay is highly, but not perfectly, correlated with low income. Thus, if policymakers really want to increase coverage, they are going to have to provide substantial subsidies since most of the uninsureds have incomes below twice times poverty.

Finally myth number 10: The combined research evidence supports doing nothing to address the problems of the uninsured today. Now, I want to be clear. Economists and health policy analysts cannot tell you as a scientific matter that you should implement new subsidies and other policies designed to reduce the number of uninsureds. We can, when we are at our best behavior, articulate and help you see the tradeoffs involved, but only you who have been entrusted with the power of the people can decide if the opportunity cost is worth it; that is, which competing priorities will and should get less attention and fewer resources. A politically neutral observer might conclude from our relative inaction on behalf of the adults in the last 35 years that the case for doing something substantial about the uninsured must be weak. I believe this is the wrong conclusion to draw from the evidence I have reported on today as well as some other recent empirical work.

The case for some kind of significant coverage expansion seems persuasive to many health economists and health policy researchers today, but perhaps the best proof of the value of health insurance lies not in statistics or econometrics, but rather in the fact that all of the health policy analysts I know—and I have lived long enough to know quite a few of them—actually seek out and keep health insurance even when self-employed. They even buy for their recalcitrant adult children when the latter emerge from college feeling immortal but also stunned at the rental price of nice apartments in our great cities.

The choice is less funny for two working parents who make, say, \$7.50 an hour and therefore earn \$30,000 a year. Their children would in most States, as Diane pointed out, be eligible for SCHIP, but they would not likely be offered health insurance at their jobs, and they make far more than most States' Medicaid income cut-off for adults. They are also not likely to spend a third or more of their income on family health insurance than the nongroup market. To

add one final touch of realism, you may assume they are healthy today.

Are we willing to require them to obtain health insurance? If they do get sick, they will use resources that will impose costs on the rest of us, and thus a requirement to purchase would be responsive to the free rider justification for universal coverage. Of course, at \$30,000 a year, they can't afford it, so we would also have to subsidize their purchase of insurance or impose an inequitable burden upon them. At the same time, they are healthy now, so the Nation would be essentially buying for them true insurance with no necessary immediate health benefits; that is, we would be buying protection from risk, a risk of potentially devastating financial, emotional, and health consequences of unforeseen health problems which could strike any of us this very afternoon.

The question comes down to, are we willing as a nation of communities to pay to protect these parents from living with this risk that we all pay to avoid for ourselves and to protect us all from free rider costs? These are the ultimate questions that only you and your colleagues can answer, but we would be glad to help. Thank you very much.

[The prepared statement of Mr. Nichols follows:]

**Statement of Len M. Nichols, Ph.D., Vice President, Center for Studying Health System**

MYTHS ABOUT THE UNINSURED

Madame Chair, Representative Stark and members of the Subcommittee, I am honored to have been invited to testify before you today on a topic of such importance to our nation, facts about those who live without health insurance. My name is Len M. Nichols and I am an economist and the vice president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization that is principally funded by The Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research. We conduct nationally representative surveys of households and physicians, site visits to monitor ongoing changes in the local health systems of 12 U.S. communities, and we monitor secondary data and general health system trends. Our goal is to provide members of Congress and other policy makers with unique insights on developments in health care markets and their impacts on people. Our various research and communication activities may be found at [www.hschange.org](http://www.hschange.org).

I am also a member of the Policy Advisory and Research Review Committees of the Economic Research Initiative on the Uninsured (ERIU), a project of The Robert Wood Johnson Foundation that convened a group of health and labor economists to sort out what we do and do not know about the uninsured in our country. The ultimate goal was to inform policy makers who may consider specific policy responses. The project was directed by Catherine McLaughlin, a professor of economics at the University of Michigan. I was a co-author of a chapter in a recently published book that grew out of this project, *Health Policy and the Uninsured* (Urban Institute Press, 2004). My chapter was titled, "Why Are So Many Americans Uninsured?"

My testimony today is organized around a theme called "Myths About the Uninsured." This theme was also the one used at a recent press briefing, which Mark Pauly—professor of economics and health care systems at the Wharton School of the University of Pennsylvania—and I did together to report on the research contained in the ERIU book. Dr. Pauly and I took turns clarifying the research pertinent to each myth, and we both essentially agreed with what the other said. Dr. Pauly has kindly allowed me to use some of his logic and words in my written testimony. I take sole responsibility for any remaining errors or ambiguity, however. In this testimony I have combined and rephrased some of the myths we used that day, and I have added one more that grows out of the spirit of the research but is wholly my contribution to your deliberations. The 10 myths about the uninsured my written testimony will highlight are:

1. We know how many uninsured there are.

2. The uninsured are all alike.
3. Coverage is coverage is coverage.
4. Health insurance would improve the health of all the uninsured.
5. The uninsured choose to be so.
6. Employers pay \$400 billion for health insurance today.
7. The decision to remain uninsured has no effect on anyone else.
8. Until HIPAA, workers were afraid to switch jobs because of health insurance.
9. Economists don't know anything about why people are uninsured.
10. The combined research evidence supports doing nothing to address the problems of the uninsured today.

Below I explain why economists think all these myths are misleading to an important degree.

**Myth #1: We know how many people are uninsured.** Forty-four million is the “official” number from the most recent Current Population Survey, but the truth could be (and is) on either side. The CPS asks: did you have health insurance at any time in the 12 months ending two months ago? Penn State Professor Pamela Farley Short’s chapter clarifies the overwhelming evidence that many respondents answer the CPS insurance questions incorrectly. Even if answered perfectly, this concept omits quite a large number of people who lack insurance for a period shorter than 12 months or the interval in which they lacked insurance did not match the particular window asked about. So the truth is that far more than 44 million are uninsured for a period shorter than 12 months in a given year.

On the other hand, other surveys make clear that the 44 million number overstates by as much as a factor of two the people who were uninsured for all of the prior 12 months. The Census Bureau’s Survey of Income and Program Participation, HSC’s Community Tracking Household Survey, and AHRQ’s Medical Expenditure Panel Survey, as well as the Urban Institute’s National Survey of America’s Families, all have probed survey respondents for years and said, now, are you really sure that you didn’t have any insurance for that time period?

The subtle lesson here is to pay attention to time frame. The longer the period of time, the smaller the number of people who are always without health insurance and the larger the number of people who are without insurance for some of the relevant time period.

Perhaps the most important thing to establish from a policy perspective is not the precise number, as long as we are confident that the number of uninsured for an entire year is in the tens of millions, and researchers are confident of this. The most important analytic measurement may be the time trend in the percentage of non-elderly Americans who are uninsured, which has recently been quite adverse. Trends are more reliably calculated, assuming that the same kinds of respondent errors and measurement imperfections are present each year, which is a reasonable assumption.

**Myth #2: The uninsured are all alike.** This is manifestly false. The uninsured tend to be somewhat lower-income and in somewhat poorer health, but because there are so many of them and because they do span various dimensions of American life, there are many who are young and healthy but there are many who are not; there are many who are reasonably well off, including a sizable fraction above the median income. And then, as is also important to note, there is a sizable fraction below the poverty line who are also sick and in a very bad way. The message of this diversity for policy design in a world of public budget constraints is that you probably want to be careful and clever in making limited funds go as far as they can toward expanding coverage. Of course, policies that are target efficient are also more complex. In addition, there are inherent trade-offs in choosing a target population, for example, in extending lower cost coverage to a larger number of relatively healthy uninsured vs. extending higher cost coverage to a smaller number who are likely to have more health risks. Value judgments are unavoidable when making actual policy choices in this case.

**Myth #3: Coverage is Coverage is Coverage.** Designs of insurance policies really do matter. Insurance is not insurance. Insurance differs in terms of the kind of financial protection it offers, in the potential for improvement in health it offers, and the humanity of the treatment when you contact the healthcare system. To put it slightly differently, imagine a policy that gave every American as much insurance as \$100 could buy. Every American would then have insurance, we’d have zero uninsured, but we wouldn’t really be in that much better of a situation than we are now.



But the punch line is that the head counts of coverage are not enough, that the actuarial value<sup>1</sup> of insurance may vary, and even given the same number of dollars spent on insurance, the consequences of insurance may be different, depending on the form that insurance takes. Furthermore, the harm of not having insurance may vary with the length of time coverage is lost, as well as with nature of the people without coverage.

Moreover, the kind of insurance that people get depends very strongly on where they get it. If they work for a large Fortune-500 firm whose benefits department is run by professionals, they will get very good and well-designed coverage. If they get it from Gus and Otto's Garage, and neither Gus nor Otto was trained as an actuary, it may not be such great coverage. And if they get it in the individual market, it depends on how good the consumers are at searching through the wide range of possibilities available to find the best buys out there compared to other less satisfying policies that are also available and may be easier to find.

**Myth #4: Health insurance would improve the health of all the uninsured.** This is among the more complicated and emotional disputes in health policy analysis. I will clarify how the literature may be correctly interpreted on what is accepted as proven now, and take some care to distinguish this from what we would like to know and from what we might think policy should do in the face of real-world imperfect knowledge.

Helen Levy and David Meltzer, both professors at the University of Chicago, were asked to review the literature to assess this question: "Does health insurance really affect health status?" They were rightly concerned that standards of proof about causation in this area have often been lower than they should have been in many published papers, even in many prestigious journals over the years. And they chose to use a standard of proof that is quite high, but is nonetheless becoming increasingly common in the social sciences, that causation is not likely to be appropriately inferred unless there has been an adequate natural experiment or a true experiment in which a representative sample of people are assigned to have or not have insurance for the duration of the experiment. This standard of proof for causation has become more widely shared as researchers have realized that there may be important but unobservable differences in people that make different choices about things like insurance, diet, exercise and education. If we merely observe what people do, it is hard to be sure what caused and what merely reflected health outcomes. For example, if some people (for whatever reason) have a low value for their health, it is likely that they will not obtain health insurance but also will not take steps (like preventive care and better health habits) that are known to affect health. We can easily observe the association of lack of insurance and low health, but it will be their low demand for health that causes the poor health, not lack of insurance *per se*.

Now, this standard of proof has rarely been met in the research literature, but when it has, the bulk of the evidence suggests that health insurance does indeed have positive effects on the health of certain populations, and indeed, those most often at the center of a policy debate: the poor, the elderly, the truly sick and children. What has not been proven by this standard is that universal coverage would improve the health of *all* of the uninsured, and this leads economists to the following three inferences. (1) Because we do not have an unbiased measure of the effect of health insurance on health in general, we cannot say with certainty that more public subsidies for health insurance for the general population would improve health status more than would an increase in the capacity of public health centers or public hospitals, better education about diet and exercise, or a more equal income distribution for that matter; (2) Understanding more about the complicated pathways that different types of people traverse from coverage to health status through health services, and indeed, health insurance and health education, would help us make far better calibrated recommendations to policymakers; (3) There are many reasons to support universal coverage, but the analytic case for the short-run positive health effects is not the strongest one, at least for the higher income and basically healthy uninsured who comprise roughly 40 percent of the uninsured today.

Another element of this generalized myth is that universal coverage would eliminate poor health status among vulnerable populations. Despite considerable policy attention and focus, rather large disparities in health care outcomes among different population subgroups persist in our country. At least part—and perhaps a very large part—of the reason lies in differential access to health insurance. Harold Pollack and Karl Kronebusch, from the Universities of Chicago and Yale, respectively,

<sup>1</sup> Actuarial value can be thought of as the percentage of expected health-related costs for an average risk person that the policy is designed to cover. It is thus a measure of generosity of a health insurance policy.

have written a chapter that focuses on access to health insurance by six subgroups that are often considered vulnerable for one or more reasons. The groups are the low-income population, children, racial and ethnic minorities, people living with chronic conditions, the near-elderly, and people suffering from psychiatric and substance use disorders.

Each group raises distinct concerns for public policy, health insurance and the healthcare delivery system. Pollack and Kronebusch conclude there are four basic reasons vulnerable populations often lack health insurance: (1) they have medical and social needs that hinder their access to good jobs and to private health insurance markets; (2) they have general economic disadvantages, including lower incomes, which impede their ability to pay for health insurance when it is available and less access to jobs with employer-sponsored insurance, which makes it cheaper; (3) they sometimes face discrimination based on race, ethnicity or language; and (4) they sometimes suffer from impaired decision-making and rather imperfect proxy decision-making. And unfortunately, many people in vulnerable populations face multiple barriers at the same time.

As an example of troubling disparities, taken from AHRQ's recent healthcare disparities report,<sup>2</sup> black women have lower rates than white women of cancer screening and higher rates of diagnosis in late stage and consequently higher death rates. These death rates apparently persist even after controlling for education and income. They also appear to persist after controlling for insurance. This suggests that insurance alone cannot solve the problems faced by vulnerable populations. Pollack and Kronebusch wrote: "The data provide ample warning that one should not oversell the possibilities of improving health status and individual well-being through expanded health coverage. Expanded coverage is unlikely to eliminate the high rates of death and illness that arise from multiple causes and require multifaceted interventions." In other words, insurance will help these populations and reduce gaps,<sup>3</sup> but eliminating the disparities gap will require multiple policy changes.

**Myth #5: Individuals without insurance choose to be so.** In some general sense this is true. No law prohibits people from buying insurance, and most could buy individual insurance, although if you are a very high-risk person you might find the price quoted to exceed what you expect to get back in benefits, and a small fraction of people are outright denied access to insurance at any price. But, more generally, if we think of realistic choice or reasonable choice for low-income people or for people at high levels of risk, if they don't have insurance now, obtaining insurance voluntarily without further subsidies is probably not a realistic option.

We also know—especially from some of the studies described in the chapter that Linda Blumberg of the Urban Institute and I wrote—that job matching is not perfect and there are some people who probably want insurance who can only find a job in firms that do not offer insurance. Now, they do not want it so much they are willing to pay whatever it may take in the non-group market, but they do want insurance and can not get it. There are also some other people who would rather have higher wages than health insurance but can only find a job in a firm that offers health insurance to them along with an acceptable wage. The out-of-pocket premium required of them may even be low enough to induce them to take-up this employer offer, but maybe not, and thus this low relative demand—or willingness to pay—for health insurance may be the core reason roughly 20% of workers do not accept their employer's offer.

**Myth #6: U.S. employers spend \$400 billion a year for workers' health care.** This issue reveals how differently economists think from most people. Imagine that somebody could wave a magic wand and end \$400 billion of employer payments for health insurance. First, the definition of "pay" in economics is not who writes a check, but the definition is wrapped up in the question, would employers then get to keep \$400 billion more of profits that they could distribute to stockholders on to increase compensation of their senior executives, or to do whatever they wanted to do with it?

And the answer that economics gives—well summarized in a couple of chapters in the ERIU volume—is no. One way to think about why the answer is no is to think about why employers offer health insurance. Now maybe some of them do it out of the goodness of their heart, and some of them do it because they think insurance makes employees healthier and therefore more productive, and under certain circumstances there may be a business case for doing that. But most employers, at least if you locked them in a room and asked them, "Why are you doing this if you

<sup>2</sup>[http://qualitytools.ahrq.gov/disparitiesReport/download\\_report.aspx](http://qualitytools.ahrq.gov/disparitiesReport/download_report.aspx)

<sup>3</sup>Hargraves, L. and J. Hadley. "The Contribution of Insurance Coverage and Community Resources to Reducing Racial and Ethnic Disparities in Access to Health Care," *Health Services Research* 38:3 (June 2003).

whine and complain about it all the time, why don't you just stop offering health insurance?" And their answer is, "Well, we need to offer health benefits to be competitive in the market for workers, to be able to attract and retain high-quality workers," which is another way of saying they offer health insurance to obtain a given quality of worker for less total compensation outlay than they would have to expend in the absence of health insurance.

And so the punch line is that if somehow employers were not allowed to spend \$400 billion on health insurance, then in order to attract the workers that they were formerly attracting with this benefit, they would have to use money or some other benefit that could well eat up or even exceed all of the savings. So that's at least one way to think of why economists are out of step with the rest of the world. Our theoretical logic—and some careful empirical work—tells us that (most) employers actually do not pay for health insurance (and by the way, then, health insurance costs are not what makes U.S. products noncompetitive internationally). Economists believe that ultimately most workers end up paying for health insurance in the form of lower wages.

This argument also works in reverse, which may be more germane for the current situation. Imagine that employers are mandated to provide health insurance, as has been passed in some states and introduced at the federal level from time to time. Who's going to actually end up paying for that? Well, the story is just the same as above but in reverse. Initially of course employers will do most of the complaining about it, as they have, and threaten to lay off workers, but that will, at least over time, soften the labor market, cause raises to be smaller than they otherwise would have been, and sooner or later, the bulk of workers will end up paying for the health insurance that policy makers gave them with the best of intentions. They'll end up paying for it themselves through reduced wages and fewer jobs unless they receive a subsidy. Of course, if they receive a generous subsidy or their employer does, that subsidy will ultimately go to workers.

**Myth #7: The decision to remain uninsured has no effect on anyone else.** An overarching feature of modern labor markets is worker heterogeneity; we all differ in many important dimensions, including our preferences for health insurance arrangements. One consequence of heterogeneity is that different kinds of compensation packages may exist in equilibrium, some with a broad array of health insurance choices attached, some with one health insurance option embedded, and some with only cash wages to entice a prospective employee to give up their leisure time. Michael Chernew and Richard Hirth of the University of Michigan focus their critical review essay on the connections between decisions made by different people in the nexus of labor and health insurance markets. This myth was chosen to highlight the reality that some workers' willingness to work at jobs without health insurance—while this may be a minority of workers today—has important consequences for the rest of us.

First and foremost, it means employers have a choice about whether to offer health insurance, and they will make this decision largely based on the preferences, expectations and productivity of the dominant type of worker they need to produce their products and services, as well as on their own unique costs of delivering health insurance to their workforce. For example, higher-wage workers are likely to be willing to pay more for health insurance in the form of reduced wages, and so employers of highly productive high-wage workers are more likely to offer than are employers who can get by with mostly lower-wage workers. This effect is amplified by our current tax subsidy for premiums nominally paid by the employer, a subsidy that works out to be roughly proportional to the marginal income tax rate of the worker. It is also amplified for large firm employers of high wage workers, since they have the lowest costs of providing health insurance, for they can take advantage of various economies of scale.

But worker heterogeneity also means that local labor market conditions can significantly affect offer rates, since firms offer only when they must to compete for the workers they want, and we do observe offer rates differ by as much as 20 percentage points across the United States. This variation in offer rates also affects ultimate coverage rates, of course. Differential offer rates and employer-sponsored insurance (ESI) coverage rates also affect the contours of the coverage problem faced by policy makers. For example, states with high offer rates find it cheaper and easier to be more generous with Medicaid and SCHIP eligibility—Minnesota and Wisconsin come to mind—than do states with very low employer offer rates, like Arkansas and Mississippi.

**Myth #8: Workers used to be afraid to switch jobs because of health insurance, and HIPAA fixed that.** "Job lock" is the shorthand term economists applied to the phenomenon of workers remaining with less productive jobs than they could get because they fear losing health insurance if they were to switch. This was

originally investigated with some vigor in the early 1990s during the debates over the Clinton Health Security Act, for it was argued that if the aggregate amount of lost productivity was large enough, there could be a very large hitherto uncounted gain to universal coverage, and thus the net cost to society might be much lower than simple budgetary cost estimates.

Since then, much research was done, and HIPAA was passed, which among other things, was designed to make the portability of insurance more real and reduce job lock. Jonathan Gruber of MIT and Bridget Madrian of the University of Pennsylvania reviewed the complex research evidence and concluded that the studies with the most defensible methods do indeed find some pre-HIPAA job-lock, though the welfare cost from this job lock is essentially impossible to quantify. This means economists cannot tell, at the moment, if additional policy interventions are justified.

Gruber and Madrian also highlight two broad reasons to believe that many workers are still reluctant to switch jobs for health insurance-related reasons, even after HIPAA: They stem from Myth #3, coverage is coverage is coverage. First, workers could have more generous coverage on their current job than HIPAA requires, in terms of pre-existing condition waiting periods, actuarial value or access to preferred providers. Second, insurance in the individual market costs more per dollar of coverage, so that higher wages—exactly equal to what the previous employer “paid” toward health insurance, for example—may not be able to make one whole. Thus, workers are often reluctant to leave a job with health insurance for a job that might pay higher wages but does not have health insurance attached. The cost advantages of group purchase are large.

**Myth #9: Economists don’t know anything about why people are uninsured.** Sometimes it seems that a normal person might listen to economists argue among themselves or read a whole book devoted to methodological flaws in prior work and reasonably conclude that economists actually think we know exactly nothing, that nothing has been satisfactorily proved, and we therefore need millions of dollars and years more to study and argue before we will be able to say anything at all that is useful to policymakers. This is not the case, and this idea is so important, I will devote the last two “myths” to embellishing the point. There are three things I think most economists actually do believe about the lack of insurance coverage. And I think the chapter by Linda Blumberg and myself make these fairly clear, even, and maybe especially, to non-economists.

1. The single most important reason people are uninsured in this country is they are not willing to pay what it costs to insure themselves. This unwillingness to pay is highly but not perfectly correlated with low income. Thus, if policy makers really want to increase coverage, they’re going to have to subsidize people, probably quite substantially, since most of the uninsured have incomes below twice-times poverty.

2. The prices people are required to pay for health insurance vary a lot across different circumstances and insurance markets. Workers at large firms probably face the lowest prices, and they, correspondingly, have the highest offer rates and the most generous policies on average. Thus, to economists, price really, really matters.

3. Even though price really, really matters, most people and firms have fairly inelastic demands for health care and health insurance. That is to say, those of us who can pay quite a bit more would pay more than we have to now before we would go uninsured, and those who do not buy it now will require substantial subsidy before they will buy it voluntarily.

**Myth #10: The combined research evidence supports doing nothing to address the problems of the uninsured today.** Economists and health policy analysts cannot tell you—as a scientific matter—that you should implement new subsidies and other policies designed to reduce the number of the uninsured. We *can*—when we’re at our best—articulate and help you see the tradeoffs involved, but only you who have been entrusted with the power of our people can decide if the opportunity cost is worth it, i.e., which competing priorities will and should get less attention and fewer resources. For let there be no doubt, if you really want to make a serious dent in the uninsured problem, you’re going to have to be willing to claim and redirect a considerable amount of public resources.

But at the same time, a politically neutral observer might reasonably conclude, from the decades we have been discussing this issue as a nation even while the number and percentage of uninsured keeps trending upward, that the case for doing something substantial about the uninsured must be widely perceived to be weak. I believe this is the wrong conclusion to draw from the evidence I’ve reported on today, as well as from the empirical work my colleagues at HSC and others around

the nation have done these last few years.<sup>4</sup> Perhaps the best evidence of the value of health insurance is not in statistics or econometrics, however, but rather lies in the fact that all the health policy analysts I know—and I know quite a few around the country—actively seek out and keep health insurance at all times, even when self-employed, and they even buy it for their recalcitrant adult children when the latter emerge from college feeling immortal but also stunned at the rental price of nice apartments in our great cities these days.

The choice is less funny for two working parents who make say \$7.50 an hour each—that’s more than \$2 above the minimum wage—and if they work full time as most do, they therefore earn \$30,000 a year. Their children would in most but not all states be eligible for SCHIP, but you can know they would not likely be offered health insurance at their jobs, and they make far more than Medicaid income cut-offs in the vast majority of states in our country. They are also not very likely to feel like they can afford to spend a third or more of their gross income on family health insurance in the non-group market. To add one final touch of realism, you may assume they are healthy today.

Are we willing to require them to obtain health insurance? If they do get sick, they will most likely access health resources that will impose costs on the rest of us in various ways, and a requirement to purchase then would be responsive to the so called “free rider” justification for universal coverage. But of course they cannot afford it, so we would also have to subsidize their purchase of it, or impose an inequitable burden upon them. At the same time, they are healthy now, so the nation would be partially buying for them true insurance with no necessary immediate health benefit, that is, we would be buying protection from risk, a risk of potentially devastating financial, emotional and health consequences of unforeseen health problems which could strike any of us this very afternoon. The question comes down to, are we willing as a society to pay to protect these parents from living with this risk that we all pay to avoid for ourselves, and to protect us all from living with their free-rider risk? These are the ultimate questions that only you and your colleagues can answer.

I devoutly wish it were otherwise, but we economists cannot tell you with certainty the best particular way to expand health insurance coverage,<sup>5</sup> but I can say the case for some kind of significant coverage expansion seems strong to many health economists and health policy researchers today. The prudent strategy in the event you do move in that direction would be to monitor the outcomes quite closely and be prepared to alter details of the program or change course altogether if credible evidence warrants it. We at the Center for Studying Health System Change and in the economics and health services research professions more generally will undertake to try and keep you well informed.

I would now be glad to answer any questions my testimony today might have provoked.

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Chairman JOHNSON. Thank you very much, Dr. Nichols. Dr. Melnick.

**STATEMENT OF GLENN MELNICK, PH.D., DIRECTOR, CENTER FOR HEALTH FINANCING, POLICY AND MANAGEMENT, UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES, CALIFORNIA**

Mr. MELNICK. Good afternoon, Chairwoman Johnson and Members of the Subcommittee. I am privileged to have this opportunity to share with you my recommendations on what Congress might do to improve the pricing information in the health care marketplace.

<sup>4</sup>B. Strunk and P. Cunningham. “Treading Water: Americans’ Access to Needed Medical Care,” *Tracking Report No. 1*, Center for Studying Health System Change, March 2002. <http://www.hschange.org/CONTENT/421/>; *Care Without Coverage: Too Little, Too Late*. Institute of Medicine, National Academy Press, May 2002; J. Hadley. “Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income,” *Medical Care Research and Review* Supplement to Vol. 60, No.2 (June 2003).

<sup>5</sup>For a range of coverage proposals developed by thinkers with many different perspectives, see the Covering America Web page at [www.esresearch.org](http://www.esresearch.org). This Robert Wood Johnson Foundation project was directed by Jack Meyer of the Economic and Social Research Institute.

Such improvements can be a first step in helping to protect the uninsured from arbitrary and excessive prices and to lay a foundation for serving individuals under the HSA insurance option.

I am a professor of health care finance at the University of Southern California, where I direct our Center For Health Financing, Policy and Management. We have been conducting analyses of hospital pricing for many years using data from California and other States. In my short time today, I hope to leave you with a better understanding of how hospital pricing as currently practiced impacts the uninsured and what might be done to improve it. My written information supplements my testimony.

I first began with two powerful trends of hospital pricing that I am afraid worsen the problem of the uninsured in America and may stifle the market for HSAs. I will then present recommendations designed to limit the negative effects of these trends. Hospital pricing as currently practiced negatively impacts the uninsured. We have witnessed a very significant and rapid increase in hospital prices over the—list prices over the last 8 years. Hospitals have two sets of prices, list prices and net prices. Hospital list prices are the standard set of prices established by hospitals each year for all their services. The list price is more or less equivalent to the rack rate that hospitals display—that hotels display for their rooms.

All patients are charged the same list price for the same service; however, very few patients actually pay the list price. Insurance companies and other third-party payers generally have contracts with hospitals which allow them to pay a discounted price that is significantly below list price. Uninsured patients, referred to in most hospital accounting systems as self-pay, are charged the list price and then, depending on the individual hospital's policies, may be offered a discount.

To illustrate how this affects the uninsured, I turn your attention to Exhibit 1 in the handout. This exhibit shows list and net prices for patients admitted to California hospitals for an appendectomy in 2002. The list price is \$18,229, the same to all patients. However, as you can see, the net price differs depending on the patient's insurance status. Managed care plans paid about \$6,000, a 66 percent discount. Medicare paid about \$4,800, a 73 percent discount from list prices. The uninsured self-pay patients are divided into two groups, those that qualify for hospital indigent programs and all other uninsured. The indigents end up paying the lowest net price, about \$1,700. Nonindigent self-pay patients paid the highest net price, about \$8,000. They did receive a discount, but it was the smallest one.

Please note that these numbers are not exact, but they do accurately portray the pattern of pricing out there. Hospital pricing strategies are driven by a complex mix of contracting arrangements as well as market forces, and as a result, hospitals have focused largely on net prices. However, since most hospitals can continue to increase their revenue from insured patients by raising list prices, there is a strong incentive for them to continue to increase list prices. The data in the attached exhibits show that list prices have increased rapidly and substantially in recent years throughout the United States. An indirect and largely, I believe, unintended affect of these trends is that they have created hardship for

the uninsured patients. In fact, hospital prices that the uninsured population pay are increasing more than any other group.

Given the incentives in the system, I believe that hospital list prices will continue to rise faster than costs and net prices, and will further exacerbate the problems facing the uninsured. In some cases hospitals do discount from list prices for self-pay patients; however, the practice of granting discounts to self-pay patients is ad hoc at best right now. The net price that an uninsured patient will pay depends on too many arbitrary factors, such as the patient's level of education, their negotiation skills, where the patient lives, the hospital they are admitted to, their ability to pay, and which collection agency their unpaid bills are sent to. Furthermore, the lack of a rational and transparent pricing system for self-pay patients may hinder development and adoption of the HSA reforms.

In closing, I have two sets of recommendations: Form a national task force to study the current patterns and practice of pricing to the uninsured; and, two, charge the task force to do the following: Develop guidelines and policies regarding pricing and payment options for the uninsured; mandate that hospitals report both the policies for discounting charges to the self-pay patients and the procedures used to ensure that all patients are aware of those policies and procedures; and, finally, mandate that hospitals annually report their actual experience publicly vis-à-vis the uninsured in terms of charges, discounts, and collections. Through mandated public disclosure and media attention, social pressure will be brought to bear on hospitals to develop fair and reasonable pricing for the uninsured. These explicit policies and better reporting can serve to moderate the negative and arbitrary effects of rising hospital charges until we have a more systematic solution to covering the uninsured and could lay the groundwork for the emerging HSA market. Thank you.

[The prepared statement of Dr. Melnick follows:]

**Statement of Glenn Melnick, Ph.D., Director, Center for Health Financing, Policy and Management, University of Southern California, School of Policy, Planning and Development, Los Angeles, California**

#### **Hospital Pricing and the Uninsured**

I will first discuss powerful trends in hospital pricing that I am afraid will worsen the problem of the uninsured in America and stifle the market for HSAs. I will then present a set of recommendations designed to limit the negative effects of these trends.

#### **Hospital pricing as currently practiced negatively impacts the uninsured**

We have witnessed a very significant and rapid increase in hospital list prices over the past 8 years in the U.S.

#### **Hospital Pricing Terminology and Practices**

To better understand hospital pricing, some terminology is required. Hospitals have two sets of prices: list prices and net prices.

Hospital list prices (more commonly referred to as gross charges) are a standard set of prices established by hospitals each year (generally) for all their services. The list price is more or less equivalent to the "rack rate" that hotels display for their rooms. All patients are charged the same list price for the same service.

However, very few patients actually pay the list price (see Exhibit 1). Insurance companies and other third party payors generally have contracts with hospitals, either directly or indirectly through rented provider networks, which allow them to pay a discounted price that is significantly below the list price. Uninsured patients

(referred to in most hospital accounting systems as self-pay) are charged the list price and then depending on the individual hospital's pricing policy, may be offered a discount. The actual amount a hospital receives from the patient will be based on this discounted price less any portion of the bill that turns out to be uncollectible.

**Hospital pricing strategies are driven by a complex mix of differing payment schemes and contracting arrangements as well as market forces.**

With the advent of selective contracting and the growth of managed care in the U.S., the practice of negotiating discounts with hospitals has become widespread. In this environment the gap between list and net prices has widened. Contracting, combined with market forces, largely drives hospital net prices. Consequently, most insurers, policymakers, and researchers have focused on net prices. However, there are a number of factors that have kept hospital list prices important in overall hospital pricing and which have contributed to the rapid run-up in list prices. These factors include:

- Not all third party payors have contracts with all providers (i.e., Some third parties pay list prices or charges).
- Many third party contracts include payment formulae where the discount is applied to list prices (or charges).
- Many third party contracts (including Medicare) have stop-loss provisions that pay on the basis of list prices (charges) above a certain threshold.
- In many cases the stop loss threshold is based on list prices (charges).
- Not all insured patients are covered by a third party at every hospital (e.g, for out-of-network use).
- Some patients have no insurance coverage (self-pay patients) and do not have access to negotiated discounted prices at any hospital.

**Since most hospitals can increase their net revenue (from private insurers, Medicare, and workers comp plans) by raising their list prices, there is a strong incentive to keep increasing list prices. Indeed, data show that list prices have increased rapidly and substantially in recent years.**

The following data provide a picture of what has happened to hospital list prices in recent years:

- Hospitals have increased their list prices much faster than their costs have gone up and much faster than their net prices (see Exhibits 2 and 3 for California data and Exhibit 4 for national data).
- The difference between hospital list prices and costs varies substantially from state to state across the U.S. (see Exhibit 5).
- The difference between hospital list prices and net prices varies substantially across hospitals within the same state (data can be obtained from the author)

**An indirect and largely unintended effect of these trends is that they have created hardship for uninsured patients—the hospital prices they face are increasing more than for any other group.**

Not only do the uninsured pay for all their care out-of-pocket, but they face higher fees for the same procedure than the insured since they do not benefit from the bargaining clout of an insurance company. In the current environment, self-pay patients are much more likely to be asked to pay the list price than insured patients. An example of this is illustrated by the data previously presented in Exhibit 1. This exhibit compares the average list price for an appendectomy in California hospitals in 2002 with the amount actually paid based on the insurance status of the patient. Uninsured patients who do not qualify as indigent (according to each hospital's criteria) pay far more than patients who have insurance coverage.

**Hospital list prices will continue to rise faster than cost and net prices, further exacerbating the hardship on the uninsured.**

With continuing managed care push back by hospitals, we will see more hospitals terminating their capitated contracts with third party payers. This will move more hospital volume into fee-for-service contracts that generally include list prices in the payment formulae, either in terms of discounts from list price or as part of stop-loss provisions. This will increase the reward to hospitals gained by raising their list prices. Under this scenario, the uninsured will continue to face higher price increases than insured patients.

**In some cases, hospitals do discount from list prices for self-pay patients. However, this policy may not be uniformly applied to all self-pay patients within a hospital and discounts vary substantially across hospitals and across the country.**

The practice of granting discounts to self-pay patients is ad hoc at best. It varies both across hospitals and within hospitals. As a result, the net price that an unin-



sured patient pays for hospital care depends not only upon his ability to pay, but also upon his level of education, negotiation skills, where he lives, the hospital he is admitted to, and which if any collection agency is retained by the hospital.

One reason for the wide variation in pricing services for self-pay patients is that hospitals have not really focused on developing an analytical capacity for retail pricing. List prices have grown very quickly and so have only recently become an important element of pricing to hospitals.

Moreover, most hospitals do not have the necessary data systems that allow them to accurately calculate how much they charge or receive from the self-pay population. Self-pay patients often start out in and are billed to a third party payor category and then end up as self-pay. Often the charge is not reclassified while any payments would be credited to the self-pay category. This could understate gross charges to self-pay patients and make it appear that hospitals are collecting a higher percentage of gross charges to self-pay patients than is the case.

**Furthermore, the lack of a rational and transparent pricing system for self-pay patients may hinder development and adoption of the health savings account (HSA) reforms.**

Individuals choosing an HSA as their primary insurance mechanism may face the same rapidly increasing list prices that the uninsured face since they will be seeking care with their own funds. Moreover, the nascent state of analytical pricing models in hospitals and the absence of management tools that I've already noted could hinder the development and growth of the retail market envisioned under health savings accounts.

#### **Recommendations**

1. Form a national Task Force to study current patterns and practices of pricing to the uninsured.
2. Charge the Task Force to:
  - a. Develop guidelines for policies and procedures regarding pricing and payment options for the uninsured.
  - b. Mandate hospital reporting of both the policies for discounting charges to self-pay patients and the procedures used to ensure that all patients are aware of the discounted payment options.
  - c. Mandate that hospitals annually report their actual experience vis-à-vis the uninsured in terms of charges, discounts and collections.

#### **Rationale**

Through mandated public disclosure and media attention, social pressure will be brought to bear on hospitals to develop fair and reasonable pricing policies for the uninsured in their communities. As a first step in easing access for the uninsured, hospitals should be required to develop explicit policies and procedures for discounting list prices or charges to self-pay patients. Ideally, the discounting schedule would be a sliding scale based on income.

These policies and procedures should be included in all mailings to patients. When patients receive their first bill, it should clearly state that they may not be required to pay the charge listed. Rather, it should inform them that they are eligible to apply for a reduced fee under the hospitals' discounting program based on specific guidelines.

These policies and procedures should also be posted at the hospital registration area and should be reported to state health departments or other relevant agencies so that the public and media have easy access to this information.

In addition to developing and publicizing policies for charging the uninsured, hospitals should be required to report their experience each year in terms of how the uninsured were billed and the final disposition of their bills. The annual reporting could be incorporated into the recent CMS rule requiring hospitals to report uncompensated care on the Medicare cost report form. Explicit policies and better reporting could serve to moderate the negative and arbitrary effects of rising hospital charges until we have a more systematic solution to covering the uninsured in the United States.

#### **Glenn Melnick**

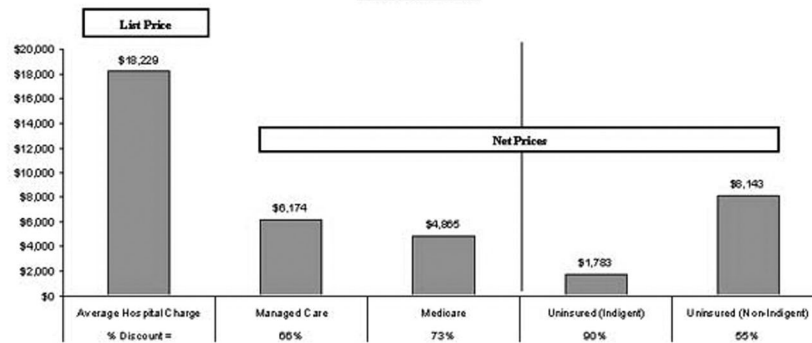
Dr. Melnick is Professor and Blue Cross of California Chair in Health Care Finance at the University of Southern California (USC).

Dr. Melnick has worked extensively in the area of health care insurance and health care market competition. Dr. Melnick's research has focused on the areas of pricing of hospital services, health insurance and health care markets and he has numerous publications in the scientific literature, including journals such as *Health*

*Economics, JAMA, Health Affairs* and many others. He is frequently called upon to provide expert advice to the Federal Trade Commission, States' Attorneys General and others. His editorials have appeared in the *Wall Street Journal* and the *Los Angeles Times*.

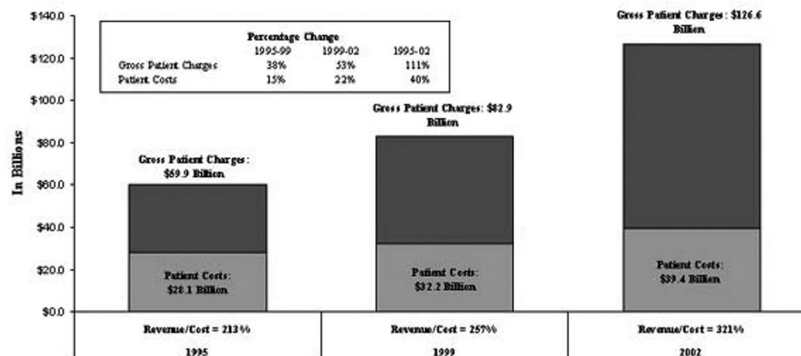
In addition to his work in the U.S., Professor Melnick works in Pacific Rim countries (including China, Taiwan, and Indonesia) providing technical assistance and training to assist countries in the development of formal health insurance systems and social programs. Dr. Melnick is also the Director of USC's International Public Policy and Management Program (IPPAM). gmelnick@usc.edu

**Exhibit 1: List vs. Net Prices for Insured Patients vs. Uninsured Patients:**  
**Appendectomy**

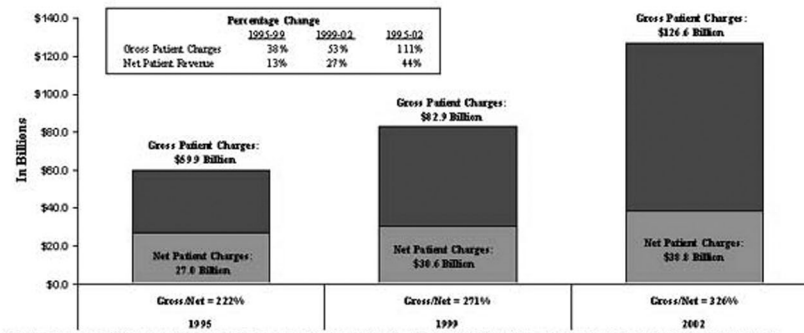


Source: Center for Health Financing, Policy and Management (Reddick, R. and Norwitz, A.), School of Policy, Planning and Development, University of Southern California  
Technical Note: Data are derived from the California Office of Statewide Health Planning and Development, Annual Hospital Discharge File, 2002, Annual Discharge Abstract File, 2002.

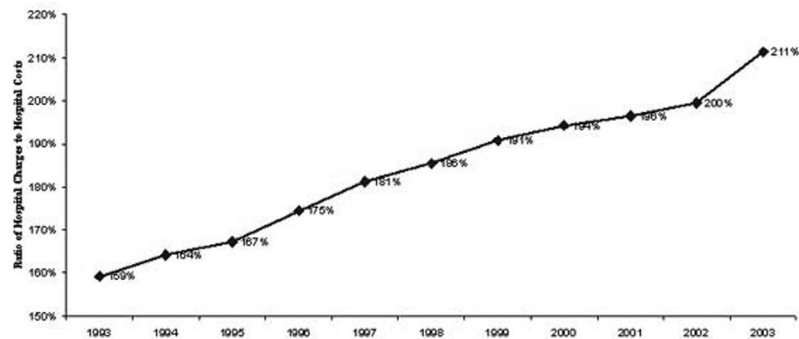
**Exhibit 2: Trends in Hospital Charges and Costs in California, 1995-2002**



Source: Center for Health Financing, Policy and Management (Reddick, R. and Norwitz, A.), School of Policy, Planning and Development, University of Southern California  
Technical Note: Data are derived from the California Office of Statewide Health Planning and Development, Hospital Disclosure File, 1995, 1999, 2002.

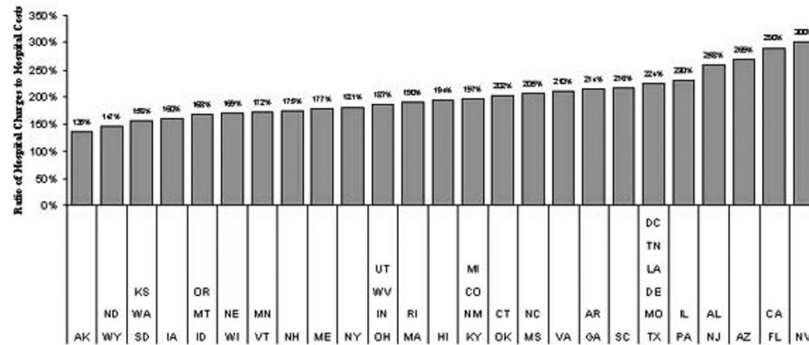
**Exhibit 3: Trends in Hospital Charges and Revenues in California, 1995-2002**

Source: Center for Health Financing, Policy and Management (Paddock, R. and Hornette, A.), School of Policy, Planning and Development, University of Southern California  
 Technical Note: Data are derived from the California Office of Statewide Health Planning and Development, Hospital Disclosure File, 1995, 1999, 2002.

**Exhibit 4: Ratio of Hospital Charges to Costs in the U.S., 1993 - 2003**

Source: Center for Health Financing, Policy and Management (Paddock, R. and Hornette, A.), School of Policy, Planning and Development, University of Southern California  
 Technical Note: Data are derived from the Medicare IPS Impact File, CMS 2003.

Exhibit 5: Ratio of Hospital Charges to Costs by State, 2003



Source: Center for Health Financing Policy and Management (Reddick, R. and Novak, A), School of Policy, Planning and Development, University of Southern California  
 Technical Note: Data are derived from the Medicare PPS Impact File, CMS 2003.

Chairman JOHNSON. Thank you very much, Dr. Melnick. Mr. Scandlen.

**STATEMENT OF GREG SCANDLEN, DIRECTOR, CENTER FOR CONSUMER DRIVEN HEALTH CARE, GALEN INSTITUTE, ALEXANDRIA, VIRGINIA**

Mr. SCANDLEN. Thank you, Madam Chairman, for the opportunity to share some thoughts with you. I think it is worth stepping back a few paces and looking at how we got here if we are looking at the underlying causes of noninsurance in this country. I think my perspective will be different than most of what you have heard in the past several years.

Generally people will cite the growth of technology, the aging population, labor market effects in looking at what is behind the uninsured. I think these things, perhaps with the exception of the aging population, are more symptom than cause, and I think the technology—for instance, in most industries technology will actually save money, but only in health care does technology actually add to overall costs. I would suggest this is because only in health care are we subject to a system of third-party payment. Third-party payment distorts the market so that economizing technologies are given short shrift while revenue enhancing technologies are highly valued.

Third-party payment itself is also not the ultimate cause, I don't believe. We have adopted a system of third-party payment largely because of State and Federal policy that has been adopted over the years. There are two things that I would like to focus on particularly today, although these are only two of many. It is Federal tax policy dating back to 1943, and the Employee Retirement Income Security Act (ERISA) that goes back to 1974.

Starting with the tax situation. As you know, the Internal Revenue Service ruled that employer-sponsored health insurance benefits would be free of taxes, excluded from income for workers, and

Congress codified that ruling in 1954. It was seen, and I think it was, a good way to encourage more coverage. The numbers of Americans with health insurance grew from about 12 million in 1940 to 80 million in 1950 to 132 million in 1960, and the coverage became more generous and more comprehensive, switching from basic hospitalization services to major medical-type approaches.

It has also had two substantial, I think, negative consequences. First of all, it advantaged only those with access to employer-sponsored health insurance. It did not advantage people that bought their own coverage or people that paid directly for services. The large amount of new money that was put into the system as a result of this incentive raised prices for everybody, including those not associated with an employer, with employer-based coverage. Now, that includes the aged and the poor, but it also includes the self-employed and people whose employers simply did not choose to provide coverage. These people found it increasingly hard to pay for their services.

In 1965, Congress addressed part of this problem by enacting Medicare and Medicaid, but the rest of the affected population, the self-employed and people without employer-based coverage, were not helped. These days, the cost of these subsidies are enormous, \$250 billion in Federal money for Medicare in 2003, \$160 billion for Federal spending on Medicaid and SCHIP, and \$180 billion for employer-sponsored coverage in 2004.

There is another consequence of this subsidy as well. The extraordinary amount of the subsidy causes that anyone who could possibly get employer-sponsored coverage will do so, leaving behind only those people who are unable to. That includes lower income workers, people too sick to work, people who are semiretired, and people in seasonal employment. This is the pool that is available for the individual insurance market, so their costs are considerably higher than the employer-sponsored pool, and coverage is ever less accessible for them.

I think ERISA has had a similar story. The primary result of ERISA was to divide the employer-based market into very large employers, influential employers who are completely unconcerned about State regulation, and small, powerless employers that were subject to State regulation. With the absence of the larger employers from the political scene, State legislators went on a feeding frenzy of regulation that raised costs for smaller employers and for individuals and made—and in some States destroyed the insurance market, and in all States making coverage much less affordable for people not in the employer-based system.

I would be happy to share additional information with you sourcing these assertions, but also discussing some of the other provisions in Federal law that have been problematic.

[The prepared statement of Mr. Scandlen follows:]

**Statement of Greg Scandlen, Director, Center for Consumer Driven Health Care, Galen Institute**

Madam Chairman and Members of the Committee,

Thank you for the opportunity to share some thoughts with you about the underlying reasons for uninsurance. I think you will find my perspective rather different than most of what you have heard in the past few years. Most commentators will

discuss the aging population, the growth of technology, labor market effects, and the like.

These all contribute, of course. But they are actually more symptoms than causes. Take technology. In most industries technology saves money. Only in health care does technology add to costs. Why should this be? Because we have a system of third-party payment that is unique to health care. Third-party payment distorts the market so that economizing technologies are dismissed in favor of revenue-enhancing technologies. Hospitals are encouraged to buy the latest whiz-bang MRI machine, but do not equip physicians with PDAs that would reduce medication errors.

But third-party payment is not the ultimate cause, either. Our system of third-party payment is the direct result of many decades of well-intentioned, but short-sighted and ultimately misguided state and federal policies. These policies have had far-reaching and negative consequences that were unforeseen (but not unforeseeable) when they were enacted.

I will deal today with two—federal tax policy and ERISA—but these are only two of the more prominent examples. Other federal laws that have contributed to the problems we face include the Hill-Burton Act of 1946, the McCarran-Ferguson Act of 1947, price controls in the early 1970s, the HMO Act of 1973, the Health Planning Act of 1974, various aspects of Medicare and Medicaid, COBRA, HIPAA, and a range of state and federal mandates.

In each case, the law was passed with high hopes and good intentions, but without adequate consideration of the long-term consequences. Some of those consequences include creating the conditions that made health coverage unaffordable for many, and preventing the market from being able to respond appropriately. Oftentimes the problems are compounded because of the way several of the laws interact, as we will see with the combination of federal tax policy and ERISA.

Let's start with tax policy. As you know, in 1943 the Internal Revenue Service ruled that employer-sponsored benefits would be excluded from income, and Congress codified that ruling in 1954. Health insurance at the time was not very expensive and relatively few Americans had any coverage at all, so the revenue effect was small. The measure was seen as a good way to encourage more coverage, and in that it was very successful. The numbers of Americans with health insurance coverage grew from about 12 million in 1940 to 80 million in 1950 to 132 million by 1960 and the kind of coverage became more generous, moving from basic hospitalization coverage to more comprehensive major medical plans.

But this growth in employer-sponsored coverage had two negative consequences:

1. Tax policy advantaged only those with employer-sponsored health insurance coverage, not people who bought their own or who paid directly for services, and
2. The large amount of new money in the system raised prices for everybody—including those with no coverage. People not associated with an employer—especially the aged and the poor, but also the self-employed and people whose employers didn't offer coverage—found it increasingly difficult to pay for medical care.

In 1965, Congress addressed part of these concerns by enacting Medicare and Medicaid for the aged and the poor, respectively. But predictably, the infusion of large new amounts of federal money on the demand side of health care resulted in even greater increases in the cost of care. In 1960, 56% of total national health spending was paid directly out-of-pocket by consumers, and only 21% was paid by state and federal governments. In just seven years, in 1967, that changed to 36% OOP and 37% by government payers. The total amount of money spent on health care rose dramatically, tripling from 1965 to 1977, and rising from 5.9% of Gross National Product to 8.3%. These demand-induced cost increases further disadvantaged people remaining outside of the subsidized system.

[As an aside, alarm over rising health care costs induced by all this new money in the system resulted in a panic to "do something" about costs in the early 1970s. What was done included the imposition of price controls and health planning activities aimed at limiting the supply of services. These were precisely the wrong responses to dealing with demand-induced inflation. The basic theory of supply and demand says that prices go up when demand outstrips supply. The way to deal with rising prices is to increase—not reduce—supply.]

Since 1965 we have had a system that generously subsidizes the elderly, the poor and people who get coverage on the job. Federal expenditures alone equaled \$250 billion for Medicare in 2003, \$160 billion for Medicaid and SCHIP, and \$180 billion in 2004 for employer-sponsored coverage. This subsidized spending clearly results in higher prices for everyone, including those who get no subsidies at all.

Some of the uninsured, perhaps one quarter of the total, are already eligible for Medicaid or employer-sponsored coverage, but have not taken advantage of the coverage. But the overwhelming majority are people who are not eligible for public programs and whose employers do not offer coverage. These people might be willing to purchase their own coverage, but there is no subsidy available to them to do so.

Someone getting coverage on the job has to earn \$4,000 in compensation to get \$4,000 in benefits. The same person who does not get coverage from an employer may have to earn \$8,000 in wages to have enough left over after taxes to pay for a \$4,000 insurance policy. Members of Congress, corporate executives, members of labor unions, all are well subsidized. But someone who is laid off from a job, a waitress in a diner, a stock clerk in a small retail store—people whose employers don't provide coverage get no help with their health premium at all. Their only choice is to buy individual coverage with after-tax dollars or go uninsured.

There is another consequence, as well. Because of the extraordinary tax subsidy provided solely to employer-sponsored coverage, anyone who can get an employer-based plan will do so. This leaves only those who cannot in the individual market. These people may be lower-income workers, people too sick to work or semi-retired, people who change jobs frequently, and people with seasonal employment. They are older, sicker and poorer than people with employer-sponsored coverage. Because they tend to be older and sicker and financially less stable, the cost of the coverage is higher than it would be for an employer-sponsored pool. There are higher claims costs because they are sicker and there are higher administrative costs because premium collection, marketing and retention are difficult. Yet these people get no help from their employers and they get no tax advantage from the government.

Some employers might be willing to contribute to the costs of coverage for these employees, but here the Employee Retirement Income Security Act (ERISA) gets in the way. The employer may not want to commit to purchasing a full-scale benefit plan with all the added regulatory reports and responsibilities. They would prefer to simply contribute money to the cost of an individual policy chosen and owned by the employee.

The tax code actually allows them to do this. As far as the IRS is concerned, employers are free to make such a contribution on a tax-favored basis. But ERISA forbids it. Under ERISA, an employer's contribution means the coverage is an "employee welfare benefits plan;" ergo, a "group" plan subject to all the requirements of any other group plan, including the HIPAA guaranteed issue requirement. Plus, state insurance law makes a clear distinction between group and non-group coverage. The two are regulated and priced separately, controlled by different sets of laws, usually offered by different insurance companies. A worker who buys his own health coverage in the non-group market must forfeit any tax advantage if the employer contributes to the cost of the policy—not due to any tax code regulation, but because of ERISA.

This is only the tip of the iceberg when it comes to problems created by ERISA. ERISA was enacted in 1974 to give employers a safe harbor from state regulations and protect the assets of a benefit plan from unreasonable costs. It was particularly important to multi-state employers who wanted to provide consistent benefits in all of their locations. But ERISA applies to *all* employer-sponsored plans (except those offered by churches and governments), not just multi-state plans, and not just to large employers. ERISA pre-empts all state laws "relating to an employee welfare benefits plan." But ERISA "saves" from pre-emption state laws that regulate insurance companies. The states are allowed to continue regulating insurance companies.

Unfortunately, this results in a division of the employer community. All are ERISA plans, but those who purchase coverage from an insurance company are indirectly subject to all the regulations that apply to that insurer. Those employers who "self-insure" their benefits are exempt from the state insurance laws. Large employers are able to self-insure and are thus exempt from state law. Smaller employers must buy coverage from insurers and are thus subject to state law.

This division affects the uninsured by disrupting the political equilibrium in the states. Large influential employers don't care what the state legislatures do, because they are completely unaffected by it. That leaves only small, powerless employers to complain when a new mandate is proposed, or new restrictions are placed on their coverage. As a consequence, advocates of more regulations and more mandates encounter little effective resistance.

In 1974, before ERISA was enacted, there were very few mandated benefits. Since that time, over 1,500 separate laws have been enacted by state legislatures mandating coverage of somebody's favorite little service. The states have also passed limits on underwriting, community rating laws, price controls, and a vast number of other laws and regulations that have destroyed the insurance market in some

states. Whatever their seeming merit, all of these laws add costs and complications to the process of a small employer providing coverage to its workers.

Not surprisingly, the cost of small group coverage has gone up faster than that of large, self-insured employers for many years. Also, not surprisingly nearly half of uninsured workers work for small companies. The “irrational exuberance” of state legislatures for onerous regulations has virtually destroyed the small group market across the country.

Let me summarize these two issues so the point doesn’t get lost. First on tax policy:

- Congress allowed employer sponsored health insurance to be free of all taxes, state and federal, income and payroll.
- The exclusion from income encouraged virtually all health care services to be paid through a third-party mechanism.
- Third-party payment created unlimited demand for health care services.
- Unlimited demand causes ever-higher prices.
- Higher prices made it difficult for people not associated with an employer to pay for their care.
- Congress responded by enacting Medicare and Medicaid to help the elderly and the poor to pay for coverage that was otherwise no longer affordable
- Medicare and Medicaid further increased demand, raising prices even further.
- The people not associated with any of these programs—especially people whose employers do not provide coverage—found it even harder to pay for health care.
- These same people had access only to individual insurance policies, but the individual market had become a “residual pool” made up largely of those people too sick or too unstable to access employer plans.
- Not only are costs higher in the individual market, but tax policy requires these people to earn up to twice as much in wages to pay for their coverage.

Next on ERISA:

- Congress allowed all employer health plans to be exempt from all state laws.
- But Congress also allowed the states to continue to regulate health insurance companies. Only those employers large enough to self-fund their benefits actually escaped state regulation.
- That left only those smaller employers who could only buy fully-insured benefits subject to state regulations.
- This eliminated the largest and most influential corporations from being concerned about state laws and regulations.
- State legislators now found little political resistance to piling on regulations.
- State legislators went on a feeding frenzy of mandates and other regulations that substantially raised the cost of coverage for small employers.
- Small employers found it ever-harder to afford coverage.
- Ever-fewer small employers provide coverage to their employees.

These are the kinds of underlying conditions that make it difficult for the uninsured to access coverage. We are not supposed to discuss solutions here, but I do want to add a cautionary note. The American people, the American health care system, and the American economy are all entrenched in this system. Even if we wanted to un-do it, it would be enormously disruptive to do it quickly. Change should be made carefully and thoughtfully. But having an understanding of this history and the consequences of well-intentioned policies should make it more feasible to tailor changes that can work.

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Chairman JOHNSON. I thank the panel very much. You have brought out a number of different things that create barriers for people getting access to health insurance. Dr. Melnick, in your charts you demonstrate how rapidly gross patient charges have grown, particularly disparate to patient costs. To what do you attribute this? Since raising their charges, I appreciate that raising their charges also has an impact on raising what they actually get for their services. Nonetheless, the difference between the publicly announced charge and the received payment is extraordinarily large. If you were to do the bar chart on the bottom of page 8 where you talk about trends in hospital charges and costs in Cali-



fornia, if you were to do that for any other product sector, would you see as big a difference, for instance, in retail clothing between the marked price and the discounted price at Marshall's?

Mr. MELNICK. I can't think of any example outside of health care. I think the peculiar aspect of the way health care financing payment has evolved over the last 10 or 15 years with contracting, and the fact that embedded in many contracts is a formula which includes charges on which some payments are made. So, what happened is hospitals figured this out and said, well, wait a second, we can raise our charges and get a higher revenue. Even if it is only a small fraction, a half of a percent, why not do it? I think that is how we got to where we are today.

Chairman JOHNSON. I think behind that lies the complexity of the Medicare payment system and there are points at which raising your charges will reap you very big benefits for small groups of patients. So, there are factors that drive this behavior. In my experience, Medicaid is the worst actor in this in the sense that the managed care plans tend to bargain across the board; Medicaid tends to have a fixed price. So, if you want to comment on that, I would be happy to hear that.

Mr. MELNICK. Well, I think, in preparing my testimony for today, one thing I am struck by is we know very little about actually this side of the whole pricing and how hospitals operate in their data systems. I think one of the things we need to do is improve that side of the hospital industry in order to understand it better and prepare for other products. I think third-party private sector contracts also many times have charges built into the contracts so hospitals are rewarded both through the Medicare side as well as through the commercial side.

Chairman JOHNSON. Thank you. Dr. Rowland, in your research, since you have done quite a lot of research, we all agree that the most disadvantaged under this system are the people who aren't poor enough to be on Medicaid or aren't signed up for Medicaid whether they are poor or not, and those who work for an employer that has a good plan or who can afford a plan themselves. What do we know, outside of the demographics, about where these people are? If they are mostly in the cities, do we know why they are not signed up for Medicaid? It is astounding that CBO could say that we have 25 percent of the children uninsured when we have two different policies to cover children. So, we need to understand more why those policies don't reach.

One of the things about SCHIP is it discovered an awful lot of Medicaid kids who were eligible for Medicaid and hadn't signed up. How big a problem is that really? How many of the uninsured live in a reasonable circumference of our community health centers which will provide them with care according to their income? So, we need to know more about who is using the resources we have out there for people under 200 or 300 percent of poverty income, and why do people who are eligible and nearby don't use it? Has any of your research led you down these particular trails?

Ms. ROWLAND. Well, our research has clearly shown that the kinds of rules and eligibility requirements in place for Medicaid prior to SCHIP, the documentation required when you apply for coverage, the face-to-face interview, the enrollment forms that were

24 pages long and asked numerous questions, the requirement to bring in birth certificates and all kinds of documentation helps to impede families from coming in to apply. So, with SCHIP, the streamlined eligibility that came in for SCHIP and then has been implemented in many States for the Medicaid population as well; the fact that a working family doesn't need to take the day off to come in and sign up.

Chairman JOHNSON. How much has that helped? Can you see that in the data?

Ms. ROWLAND. We can clearly see. We have almost doubled the number of children on Medicaid as a result of some of these practices in the States that have streamlined it, and we can show you the increased enrollment State by State from some of the statistics that we collect. So, the children's story is that when you simplify eligibility, you begin to increase participation. What we see in a State like Wisconsin is that when you cover the parents as well as the children, you have an even higher participation rate.

So, some of the lack of coverage now is that in a State like, for example, Louisiana, children are covered up to 200 percent of the poverty level, that is about \$30,000 per family of three, whereas a parent in that State is only covered up to about \$3,000 per year, so that this gap between covering the parents and the children has really resulted in some lag in enrollment.

Chairman JOHNSON. If you could provide us with that State by State data, that would be helpful.

Ms. ROWLAND. I will certainly do that.

Chairman JOHNSON. Both for children and for adults.

Ms. ROWLAND. The other issue is that the uninsured children live throughout the country, and they are often in rural areas. So, really looking at access to facilities like community health centers can help and really does help in many of the urban areas, but has been a much less available source in the rural areas.

Chairman JOHNSON. The same kind of studies about community health centers and who they serve and how that has grown and changed that you have around SCHIP.

Ms. ROWLAND. We have some studies that have looked at the number of people served by community health centers and how many of those are actually on Medicaid. About one-third of the revenue today to community health centers comes from providing services to people already on Medicaid and that helps to supplement the direct core funding of community health centers. I think that is an important thing to remember when you are looking at trying to make that access more available.

Many community health centers have also become part of the managed care plans that States contract with for their Medicaid plans. We really need to look at both the delivery side of care as well as the insurance card, because we know a Medicaid insurance card can be fairly empty if it doesn't connect you into a network of physicians. The low payments rates historically have really made access to care for some specialists especially difficult for Medicaid patients.

Chairman JOHNSON. Of course, the access to care with the community health centers is less of a problem since community health center doctors don't have malpractice costs, and the community

health centers are reimbursed on costs. They are only one of the few actors in the systems that are reimbursed that way. So, any information you can give us about—SCHIP and children and adults, but also about community health centers and any ways in which you see them participating more aggressively in the uninsured and serving the uninsured population.

Chairman JOHNSON. Now, Connecticut lost a large, very large, number of jobs when a big insurance company went under and regardless of their income, I told them to go, there was an excellent facility. It was a great boon to the community health center because all those people were full pay. Full pay at that time was \$27 for an annual physical. Now, this is 10 or 12 years ago. So, that was \$27, but at that time that was about \$60 normally. So, they are very affordable. It is mysterious to me that people of higher incomes when they are unemployed don't use these facilities.

So, I think we need to know more about who uses them, whether the unemployed go there, and so on and so forth. So, how can we use the resources we have in the system better is one of the most rapid avenues to reaching out that we would have. Then, of course, what else do we need to do. So, anyone who wants to offer on that. My time is up, and I don't want to take much more, but I do thank you, Mr. Scandlen, for your insight into current law, and, Dr. Nichols, for your work. Mr. Stark.

Mr. STARK. Thank you, Madam Chair and the panel, for your efforts in trying to enlighten us. I guess, however, there are two questions for Dr. Nichols and Dr. Rowland in particular. We talk about the diversity of the uninsured, but it is my sense that perhaps two-thirds, just to pick a number, of the uninsured come out of the lower-income population. Now, they may be lower income because they lost their employment and thereby their insurance. I don't know as there is any cause and effect here.

What would be the low income—if it is systemic, if they have been in low-paying jobs in the service sector, in jobs that are part time, in jobs that have multiple employers in the service sector, and they are unapt to have—they work for Wal-Mart, what would be your recommendation, just briefly for each of you, of reaching that 60 percent or two-thirds of the uninsured, however many there are out there? I think we would all agree that a substantial majority of the uninsured are low income. What is the best way to provide them coverage? Diane?

Ms. ROWLAND. Well, certainly I think building on the experience of Medicaid and SCHIP with children and to try to continue some of the outreach and enrollment simplification to get those children that are already eligible for coverage but are not enrolled, enrolled and into coverage.

Mr. STARK. Okay. In that, do you think you could find some studies that you could send on to me that would show that that is economically efficient, as opposed to individual policies with a tax subsidy or other alternatives that are mentioned?

Ms. ROWLAND. We have done some recent work in conjunction with Jack Hadley and John Holohan at the Urban Institute that looks at the low-income population, the coverage received within Medicaid versus comparable coverage through private insurance. In fact, Medicaid treats, because of the nature of the population it en-

rolls, a sicker population than those privately insured in the low-income groups, but does so at a much lower cost per person when you adjust for the differences in health status. The reason for that is partially the low payment rates that Medicaid pays to providers, but it is also that Medicaid operates fairly efficiently for that population. We can make that study available to you for the record.

Mr. STARK. I would appreciate it.

[The information follows:]

#### **Medicaid: A Lower-Cost Approach to Serving a High-Cost Population**

Medicaid is our Nation's principal provider of health insurance coverage for low-income Americans. The program is generally the only source of health coverage available to the 38 million low-income children and adults who are enrolled. Discussions about Medicaid spending and financing are a perennial feature of policy, legislative, and budget deliberations at both the Federal and state level. Some contend that Medicaid is excessively costly and argue that the private sector could provide coverage more efficiently. Others maintain that, for the population covered and the services provided, Medicaid is, in fact, an effective vehicle for providing coverage.

New research conducted by Jack Hadley and John Holahan of the Urban Institute examines this issue and shows that Medicaid is a lower-cost approach to providing coverage when compared with private insurance—once the poor health status of Medicaid's beneficiaries is taken into account.<sup>1</sup> The study brings new empirical evidence to bear in the debate concerning the efficiency of Medicaid versus private health insurance as a mechanism for covering low-income children and adults.

The researchers sought to assess whether, for non-elderly adults and children with incomes below 200 percent of the Federal poverty level, Medicaid is a high-cost program relative to private health insurance. Using statistical methods to control for differences between the demographic, socio-economic and health characteristics of those with Medicaid and those with private insurance, the investigators examined whether health care spending would be lower under private coverage than through Medicaid.<sup>2</sup> This policy brief highlights the key findings from this study.

#### **Study Highlights**

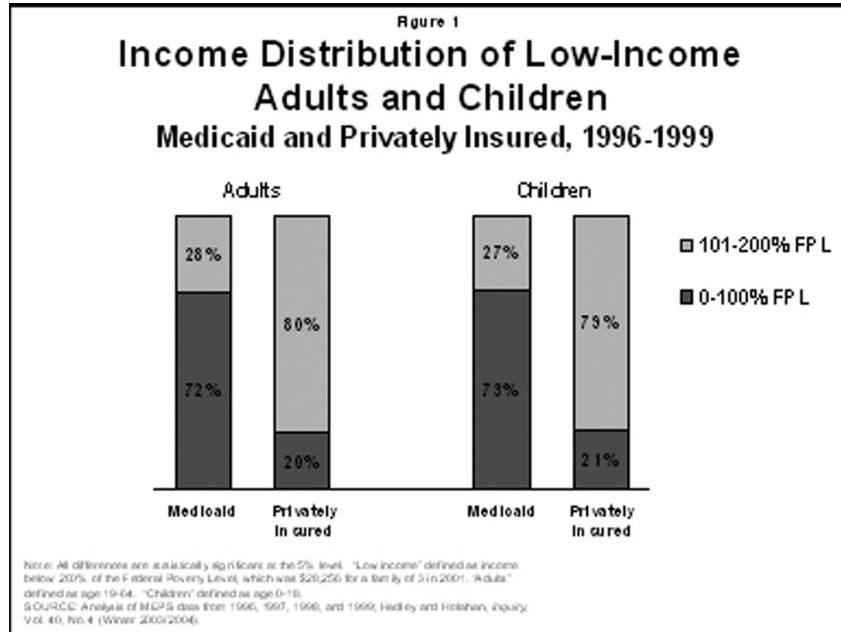
##### **The Medicaid Population is Much Poorer and Sicker than the Low-Income Privately Insured Population**

*Income.* The Medicaid population is much poorer than the low-income privately insured population.<sup>3</sup> The analysis by Hadley and Holahan indicates that the average family income for adults with Medicaid was only \$18,614—56% of the average family income for low-income adults with private insurance. Similarly, average family income for children with Medicaid was 58% of average family income for low-income children with private coverage.

<sup>1</sup>For more details on the findings and methodology described in this issue paper, see Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004. This research was supported by the Kaiser Commission on Medicaid and the Uninsured.

<sup>2</sup>For more details on the findings and methodology described in this issue paper, see Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004. This research was supported by the Kaiser Commission on Medicaid and the Uninsured.

<sup>3</sup>Hadley and Holahan based their analysis on pooled data from the Medical Expenditure Panel Surveys (MEPS) conducted in 1996, 1997, 1998, and 1999. The expenditure data were inflated to 2001 dollars using the annual percentage increase in the National Health Accounts.

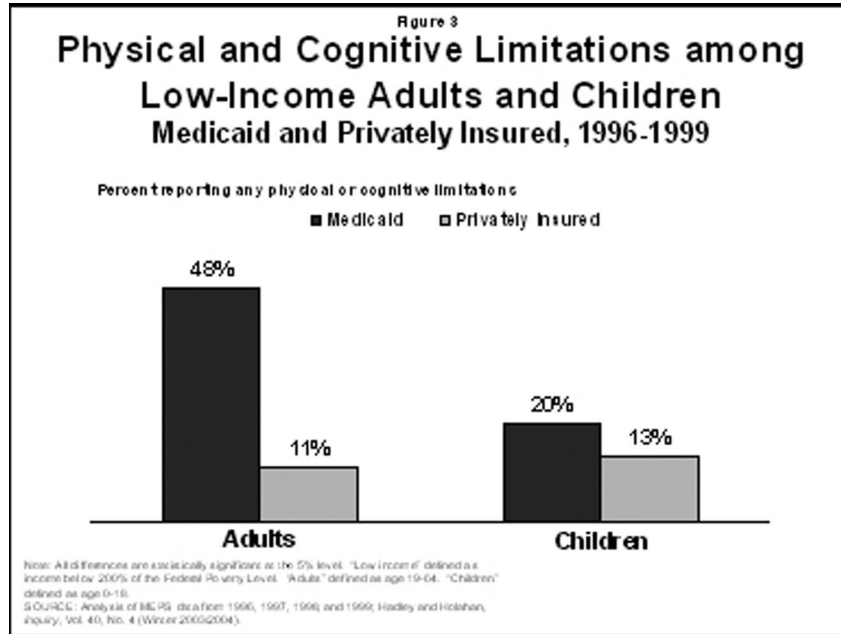


The much lower average income of the Medicaid population reflects the extremely high concentration of poverty among Medicaid enrollees. Among low-income adults, over 70 percent of those with Medicaid had incomes below the poverty level, compared with only 20 percent of the privately insured (Figure 1). Likewise, 73% of Medicaid children came from families below poverty, compared with only 21% of privately insured children.

**Health.** Health status is markedly worse among both adults and children in Medicaid than among their privately insured counterparts. Among adults, the disparity is dramatic. In particular, over one-third of adults with Medicaid report that they are in fair or poor health, compared with only 11 percent of the privately insured. Nearly 60 percent of low-income adults with private coverage reported that they were in excellent or very good health, compared with only 34 percent with Medicaid (Figure 2, Table 1).<sup>4</sup> The health status differentials for children are similar, though not as dramatic.

Disability is also much more prevalent in Medicaid. Nearly half of adults with Medicaid report physical or cognitive limitations—a proportion over four times greater than among low-income adults with private insurance (Figure 3, Table 1). Among children, the disability rate is 20 percent in Medicaid, but 13 percent among the privately insured.

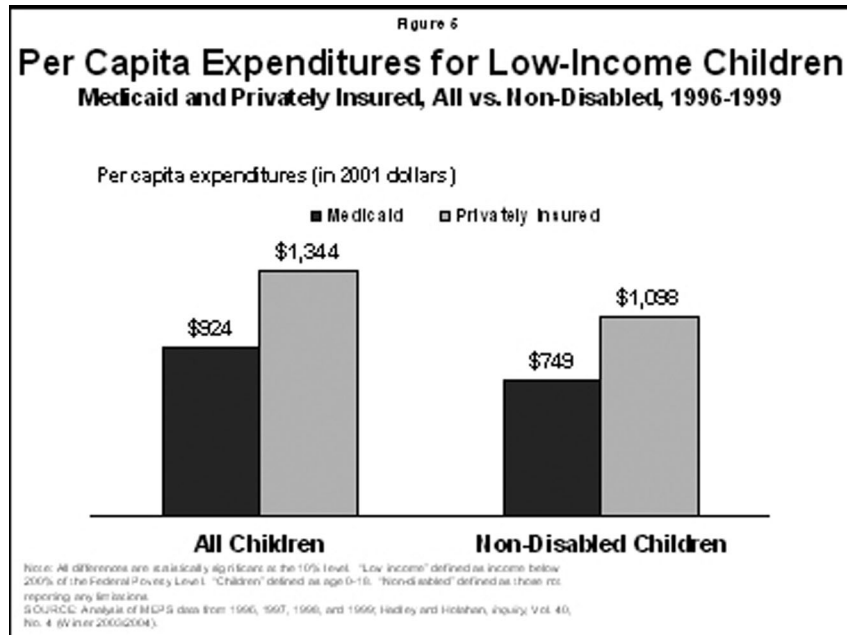
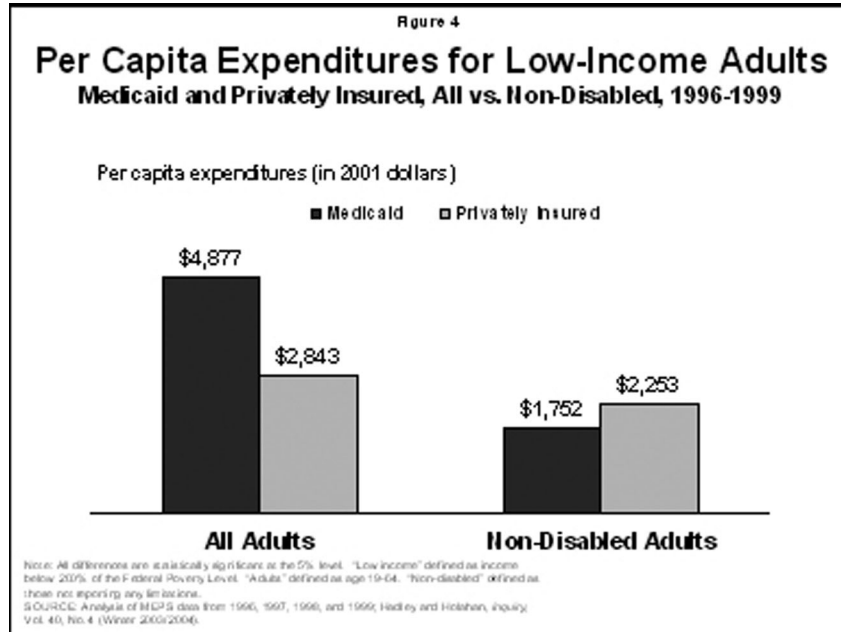
<sup>4</sup>Tables 1 and 2 appear at the end of the brief.



#### ***Health Status Explains Medicaid's Higher Per Capita Spending***

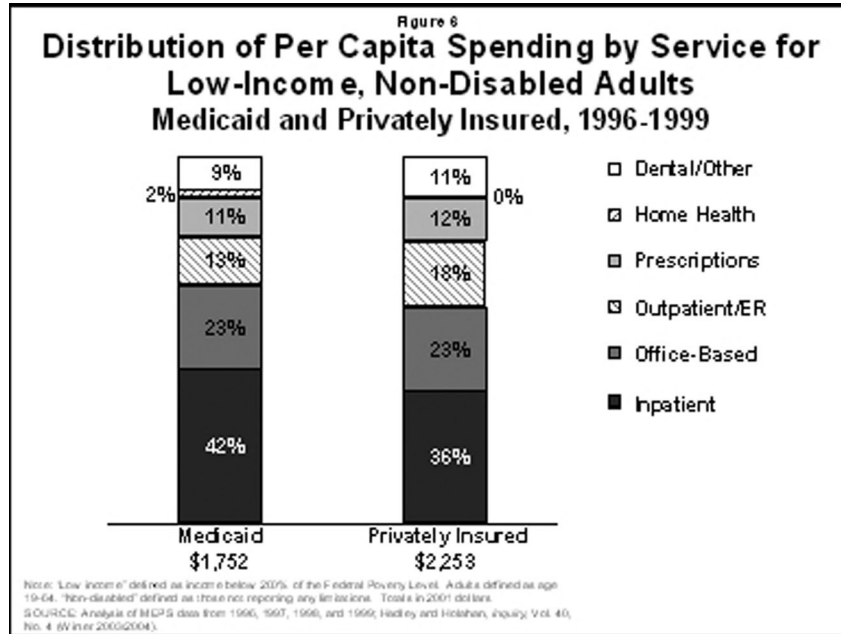
Driven largely by health status, per capita expenditures for adults with Medicaid were higher than the corresponding amounts for low-income adults with private coverage. However, when health status differences were adjusted by excluding disabled adults<sup>5</sup> from the analytic sample, per capita expenditures were significantly lower for Medicaid adults than for the privately insured. This result suggests that the higher per capita spending associated with Medicaid adults was due to the much poorer health of the Medicaid population. When all sample adults were included in the analysis, per capita spending was \$4,877 for those with Medicaid, compared with \$2,843 for the privately insured. When only non-disabled adults were included, spending per Medicaid adult dropped by nearly two-thirds, to \$1,752—about 78 percent of the corresponding private insurance level of \$2,253 (Figure 4, Table 2).

<sup>5</sup> For purposes of this analysis, "disabled" individuals are defined as those reporting any physical or cognitive limitation (see Table 1).



Among children, per capita expenditures were significantly lower ( $p = .10$ ) for those with Medicaid than for those with private coverage—even when children with disabilities, who are more prevalent in the Medicaid population, were included in the analysis (Figure 5, Table 2).

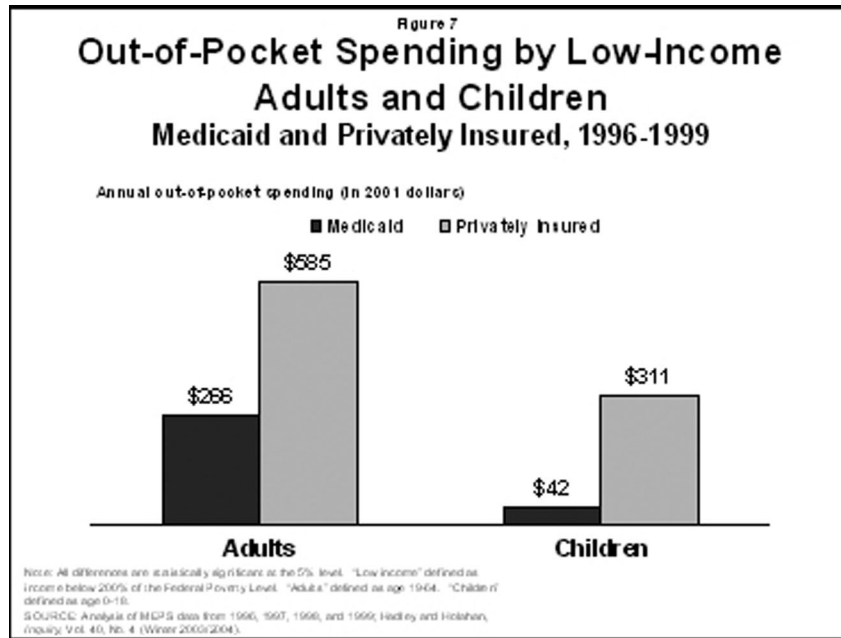
Benefits Often Cited as "Overly Generous" Account for Small Share of Medicaid Spending and a Larger Share of Private Insurance Spending



Dental and other services that states are not required by Federal law to provide under Medicaid were found to account for less than 10 percent of per capita spending for non-disabled adults in Medicaid. In fact, per capita spending for these services was higher for the privately insured than it was for the non-disabled in Medicaid (Figure 6).

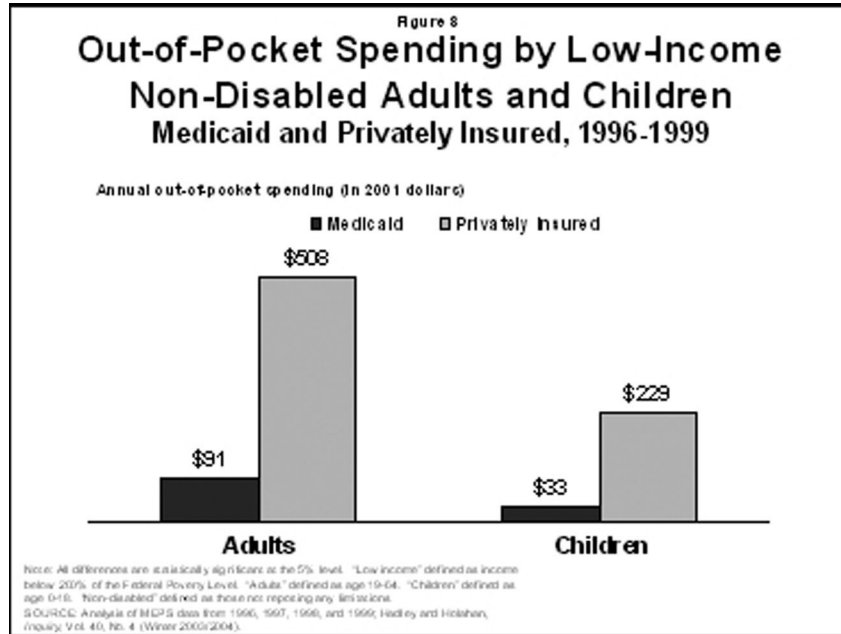


**Medicaid Protects against the High Out-of-Pocket Spending Faced by the Low-Income Privately Insured**



Low-income people with private insurance incur much higher out-of-pocket costs than do those covered by Medicaid. Presumably, the higher out-of-pocket costs they bear are attributable to cost-sharing charges and spending for non-covered benefits.

Privately insured adults below 200% FPL had out-of-pocket costs more than twice those of Medicaid adults, \$585 versus \$266 (Figure 7, Table 2). When disabled adults were excluded from the sample to increase comparability between the Medicaid and privately insured groups with respect to health status, the out-of-pocket gap widened to nearly a sixfold difference—\$508 for the privately insured versus \$91 for those in Medicaid (Figure 8). In the case of children, the privately insured spent roughly seven times more than those with Medicaid—whether children with disabilities were included or not. The limits on cost-sharing in Medicaid appear to protect its beneficiaries from large out-of-pocket obligations.



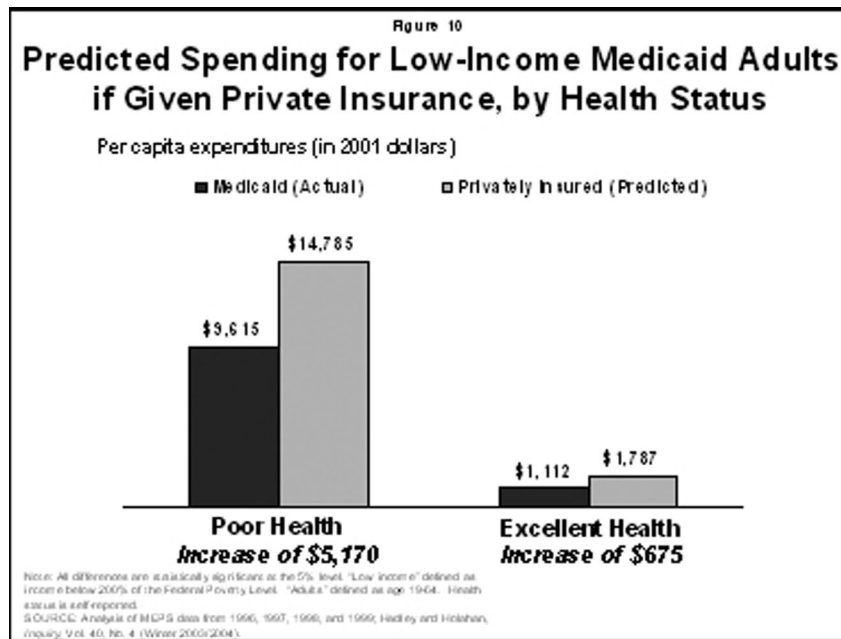
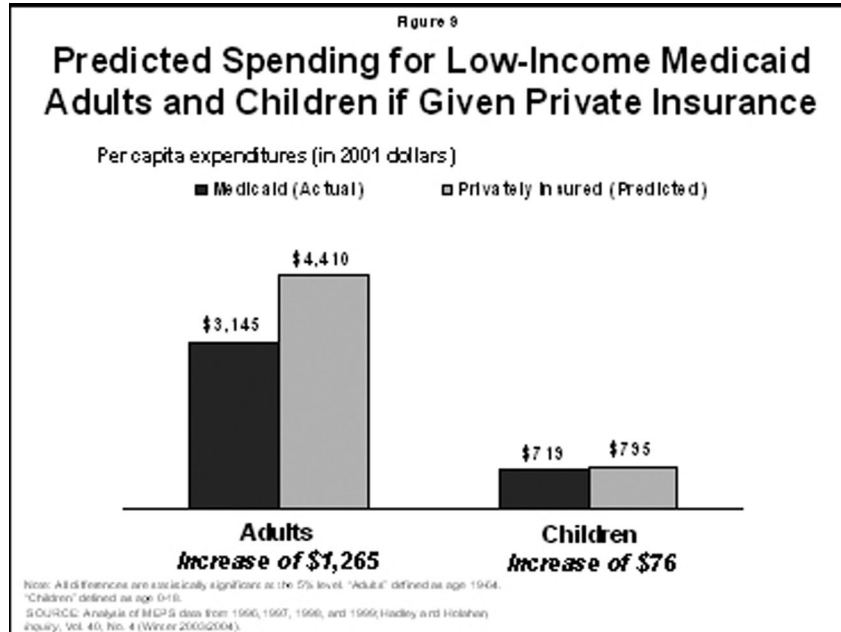
The higher out-of-pocket health care costs incurred under private coverage would be difficult for the sicker and poorer Medicaid enrollees to afford if they were enrolled in private plans unless states provided comprehensive "wrap around" or supplemental protection to cover these costs.

#### **Simulation Results: Estimates of Spending per Person under Medicaid and Private Insurance**

If the average person enrolled in Medicaid were shifted to private insurance, simulation models indicate that per capita spending would increase by \$1,265 for an adult and by \$76 for a child (Figure 9).<sup>6</sup>

Per capita spending for an adult Medicaid beneficiary in poor health would rise from \$9,615 to \$14,785 if the person were insured privately and received services consistent with private utilization levels and private provider payment rates. For an adult in excellent health, a shift from Medicaid to private coverage would increase per capita spending by \$675 (Figure 10). The results for children are generally similar, but less dramatic because the spending per person is so much lower.

<sup>6</sup>See Hadley and Holahan, 2004, for more details on the simulation models used.

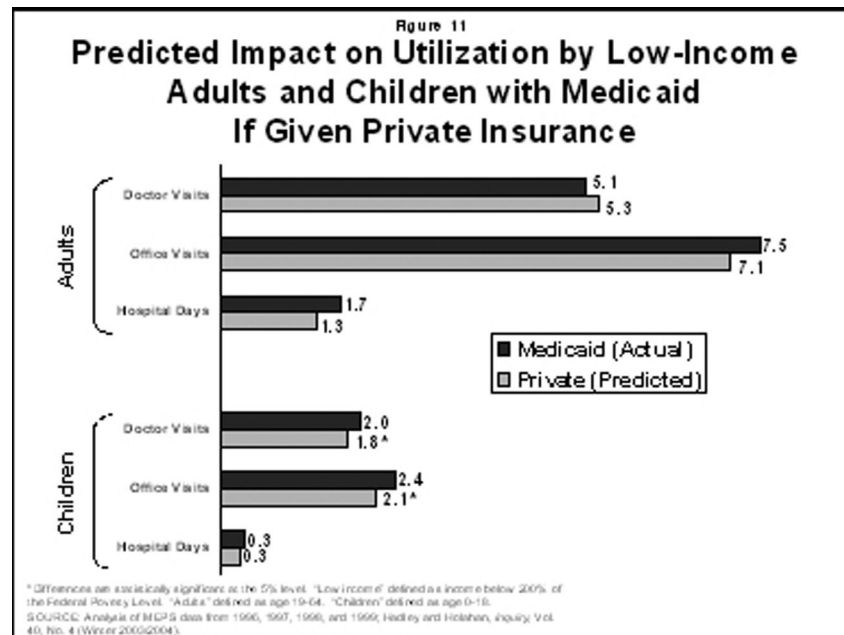


Medicaid's low per capita spending levels are due, in part, to lower provider payment rates under Medicaid than in private insurance. Inadequate payment rates have affected some providers' willingness to participate in the Medicaid program and have impeded access to care. But, as discussed below, this research indicates that utilization of basic services among Medicaid beneficiaries is generally the same

as or higher than the utilization of these services by the low-income privately insured.

#### Utilization of Services

When controlling for income, health and other characteristics, adults in Medicaid appear no more or less likely than those with private coverage to have a medical expense (i.e., use a service). Among the adults who did have an expense, total spending was significantly lower for those with Medicaid than for the privately insured, largely reflecting Medicaid's lower provider payment rates. Unlike adults, children with Medicaid were found to be more likely than their privately insured peers to use a service. However, among children with any expense, total expenditures were also lower for those covered by Medicaid.



Using simulation techniques, the predicted utilization of Medicaid adults shifted to private insurance is not significantly different from their actual utilization under Medicaid (Figure 11). However, the findings for children are different—children in Medicaid have more doctor and office visits under Medicaid than they would be expected to have if their utilization followed private insurance patterns (Figure 11). This may reflect Medicaid's emphasis on well-child care, and the deterrent effect on utilization of the much higher cost-sharing requirements of many private plans.

It should be noted that while utilization of broad categories of service was examined, possible differences in the detailed content of the care (e.g., specialist services, surgical procedures, diagnostic tests, and so forth.) between the Medicaid and privately insured low-income populations were not analyzed.

#### Discussion

When the poorer health status of Medicaid beneficiaries is taken into account, Medicaid provides coverage at a lower per capita cost than private insurance. The study findings highlight the distinctive profile of the Medicaid population, compared with other low-income people, and the special role that Medicaid plays as an insurer. Neither higher utilization in Medicaid nor the program's more comprehensive benefit structure are key factors driving Medicaid spending.

The results of this research suggest that using public funds to purchase private coverage would cost considerably more than building on Medicaid. However, any reform based on a broad expansion of Medicaid would need to address the low provider payment rates long associated with the program. Additionally, the prospect of much higher out-of-pocket costs for the Medicaid population if they were moved to

private coverage could limit their access to needed care, particularly considering their poverty and extensive health care needs.

As policymakers evaluate Medicaid's performance as an insurer for low-income non-elderly adults and children, and private-market coverage as a potential alternative, these key study findings and implications warrant consideration:

- **The high per capita spending associated with non-elderly adults and children with Medicaid, as compared with the privately insured low-income population, is due to the much poorer health of those with Medicaid.** The Medicaid population differs significantly from the privately insured low-income population. Comparisons between the two groups need to account for their different income and health profiles. Medicaid plays a critical role in our health insurance system as the source of coverage for many of the sickest and poorest Americans, whom private insurance does not reach.
- Out-of-pocket spending for the low-income privately insured is six to seven times greater than that faced by low-income Medicaid beneficiaries. These much higher out-of-pocket costs would represent a heavier financial burden for the much sicker and mostly poor population in Medicaid. If Medicaid beneficiaries were moved into private coverage without the financial protection of "wrap around" or supplemental coverage, access to care could be diminished for those most in need.
- Medicaid's comprehensive coverage of dental care and other optional services accounts for less than 10 percent of per capita spending for individuals with Medicaid; per capita spending for these services is higher for individuals with private coverage.
- **Lower per capita spending in Medicaid (adjusted for differences in health status) reflects, in part, Medicaid's lower provider payment rates, raising concerns about access to care in the program.** Although this study indicates that expected utilization of basic services by Medicaid beneficiaries is comparable to what would be expected for the privately insured, further analysis is needed to examine whether less access to medical specialists, advanced diagnostic and therapeutic procedures, and high cost drugs contribute to Medicaid's lower costs.
- Moving those who are now on Medicaid into private coverage could significantly increase health care spending and might not improve access if cost-sharing proved to be a barrier. Better access to specialty care or better quality of care through market-based coverage would need to be balanced against budget concerns, and against the risk that higher cost-sharing might diminish access to care and increase financial hardship for very low-income people.

This brief was prepared by Julia Paradise and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured and is based on research conducted for the Commission by Jack Hadley and John Holahan of the Urban Institute. For more details on this research see Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry*, Vol. 40, No. 4, Winter 2003/2004."

**Table 1**  
**Health Status and Health Conditions of Low-Income Adults**  
**and Children by Source of Coverage**  
**(2001)**

|  | <b>Medicaid</b> | <b>Private</b> |
|--|-----------------|----------------|
| <b>Adults</b>                              |                 |                |
| <b>Self-Reported Health Status (%)</b>     |                 |                |
| Excellent                                  | 13.8            | 27.7 *         |
| Very Good                                  | 19.9            | 30.8 *         |
| Good                                       | 29.1            | 30.2           |
| Fair                                       | 21.3            | 8.8 *          |
| Poor                                       | 16.0            | 2.5 *          |
| <b>Limitations (%)</b>                     |                 |                |
| Fair or Poor Mental Health                 | 25.6            | 4.3 *          |
| ADL/ADL Screener                           | 11.3            | 1.2 *          |
| Used Assistive Devices                     | 6.9             | 1.3 *          |
| Difficulty Lifting, Walking, or with Steps | 15.6            | 3.1 *          |
| Social or Cognitive Limitations            | 21.4            | 3.7 *          |
| Work/Housework/School Limitations          | 9.0             | 2.8 *          |
| Unable to Perform Activity                 | 17.8            | 2.5 *          |
| Deceased or Institutionalized              | 2.4             | 0.5 *          |
| Any Limitations                            | 48.0            | 10.8 *         |
| <b>Children</b>                            |                 |                |
| <b>Self-Reported Health Status (%)</b>     |                 |                |
| Excellent                                  | 40.4            | 49.4 *         |
| Very Good                                  | 27.5            | 31.3           |
| Good                                       | 24.4            | 16.2 *         |
| Fair                                       | 6.4             | 2.5 *          |
| Poor                                       | 1.3             | 0.6 *          |
| <b>Limitations (%)</b>                     |                 |                |
| Fair or Poor Mental Health                 | 5.2             | 2.2 *          |
| ADL Screener                               | 1.4             | 0.5 *          |
| IADL Screener                              | 10.6            | 8.6 *          |
| Limited in Any Activity (age <5)           | 1.1             | 0.3            |
| Special Group (age <5)                     | 2.4             | 1.5            |
| Deceased or Institutionalized              | 0.4             | 0.1            |
| Any Limitations                            | 20.4            | 12.6 *         |

\* significantly different from Medicaid at the 5% level.

SOURCE: Analysis of MEPS data from 1996, 1997, 1998, and 1999; Hadley and Holahan, *Inquiry*, Vol. 40, No. 4 (Winter 2003/2004).

Mr. STARK. Dr. Nichols, which way would you go to handle this group?

Mr. NICHOLS. Well, sir, I would want us to remember that the picture here is quite diverse even among the lower income uninsured. Some work for firms that actually do offer now, and they feel like they can't afford it. So, you might think about low-hanging fruit, including subsidies to people to pay their employees' share. That will end up being expensive because a lot of low-income workers who are offered today do take.

So, you have got this diversity problem which will lead to an equity problem. So, in some ways it really does depend, sir, on how much you want to spend. If you want to pay for equity, that is expensive. If you want to target the money just for those who are currently uninsured, then you might think, well, the best thing to do would be to focus on those who don't have employer offers, who don't have any other alternative. Like Diane said, you might insure them efficiently through Medicaid, but you might also give them tax credits; you might also give them access to maybe let them buy into the State employee plan. That is a big umbrella plan; it ends up being—it is like FEHBP on the State level. It ends up being an avenue that you can enroll people in every county; it ends up being a way you can guarantee choice.

So, I would submit, it depends—you have got to tell me a little bit more about which way—what your values are, what your choices are. Tell me that, and I can design a system. I would say at this point, do something, because we are looking at 40-something million. I would submit, if there is one thing I could say today that would be my main point on all of, it is we are now in a dynamic system where health care costs are growing faster than wages, and they have for 30 years. No matter what we do, that seems to be the reality and what that means at a personal level is that an increasing fraction of our workforce cannot afford health care as we know it. Thus, if we don't intervene—

Mr. STARK. Let me toss this in. Just think about it, and send me a letter if you are concerned. Half of—more than half of personal individual bankruptcies are related to medical expenses, but 80 percent of those people filing had health insurance. Now, what does that tell you? Does it begin to tell you that the health coverage or quality of their insurance is inadequate, or they wouldn't be going bankrupt? Generally they can't get the check and spend it on a new car and not give it to the insurance. Most of the health insurance goes right to the provider. So, the bankruptcy has got to be for the extra charges that the insurance didn't cover.

So, again, that is something—it is one of those little factoids that troubles me when we are dealing with—we are saying, well, we can't—Holtz-Eakin said we don't know. What is insurance? It sure wasn't good enough for the people who went bankrupt who had insurance. Let me just—one more question, if I may, Madam Chairwoman, to Dr. Melnick. Maybe you know her, maybe you don't, but missing, at least conspicuous to me but not to most people, from your testimony and your charts was Maryland, where I suspect your problems are all solved.

Mr. MELNICK. You have a good eye.

Mr. STARK. I happen to be a fan of the all-payer system, and all of your testimony wouldn't apply in Maryland, would it?

Mr. MELNICK. To tell you the truth, I didn't know it was missing, so I am not sure.

Mr. STARK. Maryland has a State-set all-payer system. So, between cost, they charge everybody the same.

Mr. MELNICK. Right.

Mr. STARK. So, there is no pricing strategy there because the prices are set. They can't offer every person who walks into any particular hospital pays the same rate no matter how they are insured. That would solve your problem, wouldn't it?

Mr. MELNICK. That would solve this problem.

Mr. STARK. Thank you. Thank you.

Chairman JOHNSON. Mr. Camp.

Mr. CAMP. I thank the Chairman. I want to thank all the panelists for your testimony today. I think it has been very helpful. What I take away from what you have been saying is that the uninsured are a diverse population that is constantly changing as some lose coverage and some gain coverage. That may mean that different solutions might be required depending on the group of people that we are trying to help.

It seems that estimates of the number of uninsured vary depending on what timeframe is used. Dr. Rowland, you testified that there were 43 million uninsured in 2002, and you gave some of their characteristics in your testimony. We have heard from CBO and others that obviously that timeframe is important when you look at this number of uninsured, and that there are more uninsured if you consider people who lacked coverage at a particular time. I think you stated that 43 million are uninsured, which is similar to CBO's number of those uninsured at particular times.

So, are your conclusions based on that same premise, that those are people who are uninsured at a particular time? If not, would those conclusions differ? Or would that change your analysis; if you considered the uninsured for an extended period of time, would you come up with a different number of uninsured people?

Ms. ROWLAND. I certainly agree with the analysis that CBO presented to you. We tend to use the snapshot of the uninsured that comes from the current population survey so that we can measure how that snapshot changes from year to year. That is where the 43 million comes from, from the latest numbers for 2002. If you look at people who have a bout of uninsurance during the course of the year, that would increase that number much higher.

One of the other surveys that we have worked with, the National Survey of American Families conducted by the Urban Institute, showed, for example, in 2002 that there were some 49 million people who were uninsured at some point during a 12-month period, and that of those, half, or 26 million, were uninsured for the whole 12 months. I think what really is important here is that there are lots of people who move in and out of coverage when they are between jobs, when they are young and move off of their family's health insurance policy, or when they are on Medicaid and their income changes and they lose coverage.

I think what really is important in looking at solutions is that we have to look at that short-term set of people with perhaps a different set of solutions than the very hardcore, long-term uninsured. That group remains primarily a very low-income population and



one which tends to have bouts of uninsurance that are 12 months or longer. So, the chronically uninsured, I think, is a different problem than those who are between jobs or certainly family situations.

Mr. CAMP. So, that your analysis of those for an extended period of time, more than a year, is similar, falls into the same range as CBO?

Ms. ROWLAND. Right.

Mr. CAMP. I appreciate that.

Dr. Melnick, you mentioned that the uninsured paid more, and they are more likely to pay above the list price. It does seem to me that lack of transparency is a real problem, because it is hard to find out what something costs around the country. You make a series of recommendations. What do you think is the most significant thing we could do with regard to that?

Mr. MELNICK. Well, I think we need to shine a light on the policies and procedures at the hospital level. We need hospitals to, first of all, look at what they are doing. A lot of hospitals, because it is kind of an artifact of their main line of business, which is insure patients, this problem has emerged—a lot of them may not even know that they are imposing a hardship on uninsured self-pay patients. They get the bills, they send the bills out, and then they turn it over to collections. So, a lot of hospitals may not know and plus, they pay the collection agency anywhere from 20 to 80 percent of the revenue that the collection agency collects. So, a lot of hospitals may not even know the hardship they are imposing on their patients. So, I think the first thing I would do is shine a light on this, force hospitals to look at it; publish their policies and procedures; make it clear to patients that when they get this giant bill in the mail, they are not responsible for that. There is a procedure to go through to get a discount.

Mr. CAMP. Thank you.

Dr. Nichols, I know my time is almost expired, but I realize we are dealing with a diverse group of people in terms of the uninsured. What is the one thing that we could do to help the uninsured? I realize that is a varied group, but what is the one thing that Congress might be able to do that you think would be most helpful?

Mr. NICHOLS. Well, it seems to me that the evidence is most clear on the low-income population being the target and would most benefit from some kind of health insurance, and their health status would be improved the most. We cover today about half of the population below poverty in various ways, mostly through Medicaid and about 10 or 12 percent or so through employer-sponsored coverage. I would submit, commit yourselves to making sure that all of the people who are below poverty are covered somehow. There are lots of different subsidy mechanisms that could get us there, but that would be a goal you should set, because you know you would do good.

Mr. CAMP. Thank you.

Chairman JOHNSON. Thank you. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chairman.

I don't know quite what to ask you, because I have sat here for years and years and years and heard the same stuff go round and round and round. People ask, well, what little thing could we do

here; one little thing we can do there? It is pretty obvious nobody wants to have a universal system, so we are going to continue to tinker with it.

I noted, Mr. Scandlen, you didn't like what State legislators did. You kind of gave a kind of an off-hand slap to the fact that legislators insure things that don't get covered by insurance companies, like Dr. Melnick. I think the States are really hamstrung in this whole business and what is fascinating about the two proposals that are floating around here, this Association Health Plan (AHP) business and HSAs, the AHP is deliberately set up to get rid of that problem with State legislatures, just knock them out of the box. Knock them out, knock out insurance commissioners, and leave the insurance industry with no regulation at all except a two-man operation over at the Department of Labor.

Now, I can't see any evidence from any—either of those proposals, either the AHP which allows small businesses to get together—they can do that now. They could do it before this bill passed. They have been—they have had that open to them for a long time. Didn't reduce costs anywhere, it didn't get any more people covered. Now we have HSAs and the idea that you would have \$5,000 to put into an account that you could start drawing out over the year for anybody making less than \$40,000 a year sounds like pretty much pie in the sky. I would like to hear from either Dr. Rowland or Dr. Nichols. Do you think either of those proposals will significantly improve the number of covered people in this country, reduce the number of covered people in this country?

Mr. NICHOLS. Well, sir, I actually testified on AHPs a year ago before the Senate Small Business Committee, and I think it is fair to say that there is a lot of passion on this issue and relatively little light. I will tell you what I believe. I believe that benefit mandates are real. They do add to costs. They don't add as much to costs as the advocates of AHPs believe.

If you look at the study done by the Department of Insurance in the State of Texas, which is not known to be a left-wing bastion, they concluded that their benefit mandates, which include inpatient mental, which, as you know, is one of the more expensive—the full month thing for alcohol and substance abuse. They concluded their benefit mandates added about 3 percent to the premium. Now, 3 percent is no small number when you are talking about premiums that are \$9,000, \$10,000. I don't want to imply it is trivial and if you are a small business on the cusp. That can make a difference, but that is not the kind of belief that I think a lot of people who advocate AHPs hold.

So, I think there is kind of a search, if you will, with all due respect, for fool's gold there. They are looking for savings that aren't really there, because at the end of the day they are going to have to pay the same costs everybody else does. What is driving cost is technology.

Mr. MCDERMOTT. It is the waste, fraud, and abuse sort of argument. That is what they are looking for.

Mr. NICHOLS. Well, sir, I believe that they are sincere. In some cases I think they do think that it is that nasty insurance company middleman that somehow thinks there are costs there to be taken that are not.

Mr. MCDERMOTT. Well, but when a State legislature requires that supplies for the diabetic patient be paid for, the number one chronic disease in the United States, the hospitalization costs, all the problems that come, all the disability costs that come out of uncontrolled diabetes, do you think that that is a wasteful effort on the part of the State legislature?

Mr. NICHOLS. No. I believe a number of studies have found that even if you didn't have specific things mandated, as you know, most physicians who are going to try to get their patients the right care, which is true everywhere, are going to find a way to make what is needed covered. So, that is part of the reason, by the way, the benefit mandates studies don't find all that much of a cost increase, because the reality is they are getting that stuff anyway, and they are going to get it. What you don't get if you don't have mandates are things like in-vitro fertilization and in some cases maternity care, which is not sold in the nongroup market as a matter of course.

Ms. ROWLAND. I would also point out that while we have talked about the diversity in uninsured, the diversity of small businesses in America is also something that you have to take into account. The majority of the small businesses that don't offer health insurance coverage tend to have a very low-wage work force where I think some of these efforts would be far less effective than in areas where the work force has a higher income. We have begun to start doing some modeling of the HSAs to see what the take-up rate might be and hope to have those results in a few weeks.

Mr. MCDERMOTT. I would like to see them when you have them done. Thank you, Madam Chair.

Chairman JOHNSON. I hope you will also model the HSAs, because the—

Ms. ROWLAND. Actually, it is the HSAs that we are modeling.

Chairman JOHNSON. The other proposals do get small business out from under State mandates the very way big business is out from under State mandates. The fact that big business offers roughly the same spectrum of benefits indicates that mandates aren't the key difference. On the other hand, all the little different mandates in high-mandate States do mean that you have to insure to a higher standard. In Connecticut, which is a high-mandate State, I am being told over and over again we could cut premiums 10 percent if we could choose of the mandates the basic ones that everybody offers.

So, while we don't know exactly what it will cost, the idea that I am bound by what the legislature does—and the legislature is going to do what is politically useful—is a problem. Then don't underestimate the power of bargaining. The big difference between these associated health plans or the HSAs is that you are going to have an employer group bargaining price, and your charts say loud and clear what a big difference that makes.

So, as you look at HSAs, one of the things about HSAs that could make a huge difference is employer creativity and being able to add more in a good year and less in a poor year so that they are not obliged. With a rollover capability, they can even have some variation of benefit depending on catastrophic problems or big health problems.

So, there are a lot of permutations of HSAs. People will have a lot more control over what they look like, both the employees and the employers. So, it is hard to model, but I think we do need to think about it. What I want to ask you is do we know anything at all about how many of the—what percentage of the uninsured have a health problem during their spell of uninsurance by group; the under 4 months, 4 months to 12? Obviously, people who are uninsured for 12 months, of course, will access the system.

Mr. MELNICK. The Institute of Medicine study reported statistics of 62 percent of the uninsured use health services while they are uninsured, about 1 in 30 use inpatient care, and about 1 in 15 use the emergency room, and a higher percent use physician services as well.

Chairman JOHNSON. This includes the long-term uninsured as well?

Mr. MELNICK. Correct.

Chairman JOHNSON. Do we have any breakdown?

Mr. MELNICK. I can get you that.

Chairman JOHNSON. If you will get that to me, I would be interested in that.

[The information follows:]

#### Health Services Utilization and Spending by the Uninsured

The uninsured, while they use fewer services than the uninsured, still use health services during periods without health insurance coverage. Several researchers<sup>1,2</sup> have utilized the Medical Expenditure Panel Survey (MEPS) to study and compare utilization patterns for the uninsured and insured populations. Provided below are three tables based on 1996 data from this prior research to provide a picture of utilization and spending patterns of the uninsured (for different time periods) compared to the insured.

#### Probability of Using Health Services

Table 1 presents data comparing the probability of using different kinds of health services depending on whether an individual is insured or uninsured for a full year. In general, the insured have a higher probability of using all health services, except for hospital emergency care. A number of other key findings include:

For under-65 population, 89% of the people who were privately insured for the full year in 1996 used at least one health service, compared to 62% of the people who were uninsured for the full year in 1996.

4.6% of privately insured population used inpatient hospital services compared to 2.9% of the uninsured.

The percentage of privately insured population was more than double compared to the percent of uninsured population using services such as Outpatient hospital (13.4% vs. 6.2%) and Dental (53.1% vs. 20.4%).

A larger portion of privately insured population used preventive care services compared to the uninsured.

#### Total Spending and Out of Pocket Spending

Table 2 presents data on total spending from all sources on behalf of the insured and uninsured and out of pocket spending by the insured and uninsured. The estimates of per capita medical care spending are for the under-65 population and include estimates of the uninsured for an entire year or part of a year. A number of key findings include:

Total per-capita spending for the uninsured (for the entire year) was about \$923 per person compared to \$2,484 per person for privately insured and \$2,435 per person for publicly insured.

Total per capita spending on behalf of the uninsured (for the entire year) was substantially below the insured population—about 38% of the total spending by an insured person.

For the uninsured population (including those uninsured for the entire year or part of the year), total per-capita spending on medical was about \$1,335 per person

This represents about 54% of total per-capita spending compared to an insured person.

Average per capita out-of-pocket spending for an uninsured (for a full year) person was \$426 compared to \$402 for a privately insured for the entire year.

Out of pocket spending by the uninsured was not substantially different from the insured population in 1996.

#### Financial Burden

A final measure of the effects of being uninsured is the financial burden of out-of-pocket spending on uninsured families. Table 3 presents estimates of the percent of privately insured and uninsured families that spent greater than 20% of their annual income on health care in 1996. A number of key findings include:

Overall, about 4% of the uninsured families and about 1.1% of the privately insured families spent greater than 20% of their family annual income on health care.

For poor families (income less than or equal to Federal poverty line), and for low income families (125–200 percent for Federal poverty line), a greater portion of the privately insured families spent more than 20% of their annual income compared to those that were uninsured.

#### References

<sup>1</sup>Taylor, Amy K., Joel W. Cohen, and Steven R. Machlin. 2001. Being Uninsured in 1996 Compared to 1987: How Has the Experience of the Uninsured Changed Over Time? Health Services Research 36(6, Pt. II): 16–31.

<sup>2</sup>Hadley, Jack and John Holahan. 2003a. How Much Medical Care Do the Uninsured Use and Who Pays for It? Health Affairs Web Exclusive (1): W66–W81

#### Tables

**Table 1: Use of Services by Full-Year Uninsured and Full-Year Privately Insured Individuals Under Age 65, 1996 (percentage with use)**

| Service                               | Uninsured | Privately Insured |
|---------------------------------------|-----------|-------------------|
| Any Service                           | 62.0      | 89.0              |
| Inpatient hospital                    | 2.9       | 4.6               |
| Outpatient hospital                   | 6.2       | 13.4              |
| Emergency Room                        | 11.5      | 11.0              |
| Office-based physician                | 41.3      | 71.3              |
| Office-based nonphysician             | 13.6      | 25.8              |
| Prescription medications              | 40.6      | 66.1              |
| Dental                                | 20.4      | 53.1              |
| Preventive Care                       |           |                   |
| Blood pressure check within last year | 50.6      | 76.9              |
| Ever had a mammogram*                 | 70.6      | 88.2              |
| Pap smear within last year**          | 36.1      | 63.7              |

\*Limited to women aged 50 to 64

\*\*Limited to women aged 17 to 64

SOURCE: Taylor et al., 2001. MEPS 1996.

**Table 2: Total and Per Capita<sup>a</sup> Medical Care Spending, by Insurance Status, 2001 (estimated)**

| Insurance Status                                | Per Capita <sup>a</sup><br>Spending (\$) |
|---|--|
| Private Insurance, Full Year                    | 2,484                                    |
| Public Insurance, Full Year                     | 2,433                                    |
| Uninsured, Full Year                            | 923                                      |
| Total Uninsured (full and part year)            | 1335 <sup>b</sup>                        |
| Mean Out-of-pocket spending (Uninsured)         | 426                                      |
| Mean Out-of-pocket spending (Privately Insured) | 402                                      |
| Total Population <sup>a,c</sup>                 | 2,163                                    |

a Civilian, noninstitutionalized population under age 65, excluding people with any Medicare coverage, nursing home, and long-term hospital care.

b No Adjustment for MEPS undercount of uncompensated care.

c Entries do not sum to total because of rounding.

SOURCE: Hadley and Holahan, 2003a. Pooled data from the 1996, 1997, and 1998 MEPS, projected to 2001 levels.

**Table 3: Percentages of Families with Out-of-Pocket Expenses 1996  
Greater than 20 Percent of Family Income for Full-Year Uninsured  
and Full-Year Private Insured Families, 1996<sup>a</sup>**

|                                    | Uninsured | Privately Insured |
|------------------------------------|-----------|-------------------|
| Total Population                   | 4.0       | 1.1               |
| <i>Individual Characteristics</i>  |           |                   |
| <i>Race<sup>a</sup></i>            |           |                   |
| Hispanic                           | 2.9       | 0.4               |
| Black                              | 4.6       | 1.0               |
| White                              | 4.0       | 1.2               |
| Other                              | 6.2       | 0.8               |
| <i>Health Status<sup>b,c</sup></i> |           |                   |
| Good to excellent                  | 2.6       | 0.8               |
| Fair to poor                       | 12.2      | 5.1               |
| <i>Poverty status<sup>d</sup></i>  |           |                   |
| Poor                               | 8.7       | 13.4              |
| Near poor                          | 8.3       | 4.6               |
| Low income                         | 1.7       | 1.9               |
| Middle income                      | 0.6       | 0.6               |
| High income                        | 1.7       | 0.2               |

<sup>a</sup> Analysis includes only individuals under 65

<sup>b</sup> Refers to Family Head

<sup>c</sup> In 1996, health status was measured on a five-point scale (excellent, very good, good, fair, poor)

<sup>d</sup> Poor refers to income less than or equal to the federal poverty line; near poor, between the poverty line and 125 percent of the poverty line; low income, over 125 percent to 200 percent of the poverty line; middle income, over 200 percent to 400 percent of the poverty line; and high income over 400 percent of the poverty line.

Chairman JOHNSON. Then the other thing that does continue to frustrate me, How much do you know about—there is money in the system now for the uninsured, and you have talked about Medicaid money and SCHIP money. States are cutting back on Medicaid, in case you didn't notice. The Federal government's budget is stressed. I believe budgets are going to be stressed at both the local and the State level, no matter which party is in power, for at least a decade, if not for 20 years. So, I am not optimistic about solving this through annually appropriated programs.

I am interested that the President put 70 billion dollars in over 10, even in this year's budget for the uninsured. So, there is some money allocated to this. In none of this conversation—this is exactly the same hearing we had 2 years ago, and yet this Administration has committed itself to and is methodically doubling the number of community health centers, and they expect that next year, with the additional allocation they are putting in, that they

will be providing total coverage for 15 million uninsured and underserved individuals. About 7 million of these are in rural areas.

We need to know what is happening as these expand. Who is being served? Are they Medicaid people? Are they SCHIP people? Are they uninsured? Are they underinsured? Not to know that does really weaken our ability to move forward. There are so many urban areas in which there are outstanding multiservice clinics, and they do mental health, and they do dental. So, why is it we have completely neglected in our study of the uninsured who is going there?

Now, what do we know about disproportionate share hospital (DSH) payments? How effective are DSH payments? Are they just actually covering overhead for some of these people that you charge who it turns out are paying more than any average bloke, more than any other payer? So, what do we know about DSH money? It is big, and we give it to a hospital in ways unrelated to the burden they carry. So, what do we know about that money? What do we know about indirect medical education money and its relationship to uninsured?

So, I hope that, given your resources, you will help us narrow this problem beyond the kind of definition we have given it today, because the debates to this point have covered exactly the kinds of things we have talked about today. Clinton laid down the challenge to the Congress to provide universal health care to all Americans. There was a bipartisan bill, Rowland and Michel, that met that challenge and had a majority vote, and that is why it was not allowed to come to the floor of the House. It covered everybody. That last segment it covered through means tested premiums so everyone would have access, but it did a number of other things.

So, it isn't that we haven't thought about this a lot at the Federal level. We have. It is hard, because nobody understands the interactions of what happens at the end if we subsidize premiums. I have been amazed at how many small companies I represent, small manufacturers, where the employee pays 50 percent of the premium. That is tough. So, we need to be thinking more clearly about how do we reach and how do we do it in an affordable way, and how do we do it to encourage modest use of our resources.

I am surprised that you haven't talked more about consumer involvement. One of the things that is dramatic about disease management—and I want to commend the Administration right here and now for offering to pay half the cost of implementing disease management programs in Medicaid because they pay back so fast. It will be budget neutral for the States in a year or two. It is just astounding for people with chronic illness. We need to think about this problem: Who is it that is uncovered that needs help, where do they live, who could they go to? Do we need a combination of community health center expansion and special payments for physicians in rural areas who just take all the people who are uncovered?

We need to think more specifically about the nature of this problem. I appreciate your input. It has been very good. It has been broad, and it has brought back to the table the basic research and state of knowledge about this issue in America. It isn't exactly the information that can drive specific solutions. If we are going to do



specific solutions, we need to think about the next step. I hope to have your help in doing that. Thank you very much for being here. The hearing is adjourned.

[Whereupon, at 4:00 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

#### **Statement of AdvaMed**

AdvaMed is pleased to provide this testimony on behalf of our member companies and the patients and health care systems we serve around the world. AdvaMed is the largest medical technology trade association in the world, representing more than 1100 medical device, diagnostic products, and health information systems manufacturers of all sizes. AdvaMed member firms provide nearly 90 percent of the \$71 billion of health care technology products purchased annually in the U.S. and nearly 50 percent of the \$169 billion purchased annually around the world.

AdvaMed shares the concerns of the Members of Congress, the Administration and millions of working Americans about the number of people in our country lacking access to affordable health insurance today. Our nation enjoys the best health care system in the world, and everyone should have full access to it. While today's market-based system provides insurance coverage to the majority of Americans, and along with it access to most of the latest, breakthrough technologies, some 43 million Americans are currently uninsured.

#### **The Benefits of Access to Health Care Insurance and Advanced Treatment**

In addition to the personal benefits to securing individual insurance, there are also larger benefits to the health care system and society for reducing the number of uninsured. An Institute of Medicine (IOM) report published in June 2003 estimated that the benefits from health years of life gained by providing continuous insurance coverage are greater than the social costs of providing it. Specifically, the report estimated the potential economic value from better health outcomes from uninterrupted coverage is between \$65 and \$130 billion each year.

A paper published by David Cutler and now FDA Commissioner Mark McClellan in the Sept/Oct 2001 *Health Affairs* noted the net benefits of new technology for several conditions, including cataracts, depression and heart attacks. A review of the findings estimates that more than \$1.1 billion is lost annually from lack of access to new technologies for treatment of the three specific conditions—an annual loss of around \$350 in excess morbidity and mortality per uninsured person in the age group studied.

#### **Incentives to Help Make Insurance Coverage More Affordable**

To bridge the current gaps in insurance coverage, AdvaMed has consistently supported maintaining tax incentives to encourage companies to offer health benefits to their employees—including refundable tax credits similar to Trade Adjustment Assistance (TAA)—as well as expanding tax incentives to allow individuals to more affordably purchase coverage. As supporters of market-based health care and competition, AdvaMed also believes consumers should have a wide choice of health plans and coverage options that allow them to select those that best fit their needs.

To expand the number of choices available, AdvaMed supports the creation of Individual Membership Associations or Association Health Plans to allow groups to leverage size for more affordable health options, as well as the expansion of Health Savings Accounts, which have already helped address the insurance needs of a select group of previously uninsured Americans. To address the many problems facing individuals with uninsurable medical conditions, AdvaMed also supports efforts to encourage states to offer “risk pools” that help them access insurance that will meet their complex and costly health care needs.

#### **Innovation Also Helps Reduce Health Care Costs and Makes Coverage More Affordable**

America is undergoing a revolution in medical technology. Through advances in technology we can detect diseases earlier when they are easier and less costly to treat, provide more effective and less invasive treatment options, reduce recovery times and enable people to return to work much more quickly. Medical technology has advanced to the point where it is fundamentally transforming our health care system in ways that improve quality and reduce costs. For example:

- Three types of laparoscopic surgery have generated approximately \$1.9 billion annually in increased productivity by enabling people to return to work more quickly, according to a study by DRI–McGraw Hill.

- Angioplasty and other minimally invasive heart procedures, for example, have greatly reduced the need for riskier, more expensive heart bypass procedures. An angioplasty procedure costs \$20,960 on average, compared to \$49,160 for open-heart surgery. Surgeons can complete an angioplasty procedure in 90 minutes compared to 2–4 hours for open bypass surgery. Patients can leave the hospital in one day instead of 5–6 days, and recovery only takes one week rather than 4–6 weeks for bypass.
- Total knee replacement produces an average one-time health care cost savings of \$50,000 per patient; a savings of \$11.5 billion in 1994 alone, according to the American Academy of Orthopedic Surgeon (AAOS).

An article in the *Washington Post* highlights another of the many advances transforming health care delivery: a health care information system that alerts doctors at Brigham and Women's hospital to potentially dangerous medical decisions. The system has cut the medication error rate at Brigham by 86% compared to 10 years ago.

Information systems like these can dramatically improve the safety and efficiency of health care delivery and help reduce health care costs. Automation in the insurance industry alone could save an estimated \$20 billion. That is why both the President's Information Technology Advisory Committee and the Institute of Medicine report on health care quality have stressed the need for a new health information infrastructure.

Steady declines in mortality rates, medical procedure times, hospital stays and patient recovery times all illustrate the emergence of the New Health Economy. Gains in workforce productivity and accelerating declines in disability rates point to this shift as well.

In order to reap these benefits, advanced medical technologies must be rapidly assimilated into the health care system. The Institute of Medicine's report, "Crossing the Quality Chasm," underscored this point, stating: "Narrowing the quality chasm will make it possible to bring the benefits of medical science and technology to all Americans in every community—and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce."

### Conclusion

Again, AdvaMed applauds Congress for addressing the many needs of the uninsured in America. We look forward to working with the Congress and the Administration on efforts to help increase access to affordable coverage, as well as improve the quality, efficiency and cost effectiveness of the health care system through innovative medical technology.

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### Statement of Catherine M. Murphy-Barron, American Academy of Actuaries

The American Academy of Actuaries' Uninsured Work Group appreciates the opportunity to provide comments on issues concerning Americans without health insurance. The Academy is the non-partisan public policy organization for actuaries of all specialties in the United States.

The U.S. Census Bureau estimates that more than 43 million non-elderly Americans did not have health insurance in 2002, an increase of more than 2 million from 2001. A solution to the uninsured problem has so far been elusive, but the issue is again moving to center stage. The actuarial profession has extensive experience designing, pricing, and managing health insurance coverage for individuals, employers, and public programs, including Medicare and Medicaid. As the actuarial profession's voice on public policy issues, the American Academy of Actuaries has many insights that may benefit members of Congress as they design proposals to provide health coverage to the uninsured.

This document identifies many, but not all, of the myriad issues that should be considered when designing and evaluating proposals to expand health insurance coverage. Addressing these and other issues should help minimize any unintended consequences and increase the chances for success of any such proposal. This document does not cover implementation or administration, both of which will be critical to the success of any new initiative. Rather, in the sections that follow, we identify issues related to: the target population(s); the benefit packages; the costs to individuals, employers, and states; the impact on the health insurance market; the impact on regulation; and the impact on overall health costs.

### **Who Is the Target Population?**

The uninsured population is not a homogeneous group. It includes, among others, low-income workers who do not have access to or cannot afford employer-sponsored coverage, early retirees not yet eligible for Medicare, adults who do not feel that insurance is a good way to spend their money (these people are often young, but not always), individuals ineligible for or unaware that they are eligible for public programs, and unhealthy individuals who cannot obtain insurance at any price.<sup>1</sup> A proposal could use a single approach to increase coverage among the uninsured, or it could use different strategies for different segments of the uninsured.

#### ***Who is the target population?***

- What uninsured population subgroup(s) does the proposal target?
- How well does the proposal target the intended group(s)? What is the expected participation among the intended group(s)?
- Will other groups also participate? If so, are they currently insured or uninsured?
- How will the eligible population be contacted and enrolled?

#### ***What are the conditions of eligibility?***

A proposal may offer direct insurance coverage through a public program such as Medicaid, a premium subsidy for use in the private insurance market, or some other approach.

- Under what conditions does an individual or family member become eligible for coverage or premium subsidy under the proposal?
- Is there a requirement to be uninsured for a certain period in order to be eligible for coverage?
- How long will an individual or family member be eligible?
- Is the proposed coverage meant to be permanent or transitional? For example, is eligibility tied to being unemployed? Is eligibility tied to ineligibility for other private coverage, regardless of cost?
- If the proposal relies on public program expansions, how will the eligibility rules differ by state?
- If the proposal relies on private coverage expansions, will plans be widely available, regardless of state or rural/urban location?

#### ***What are the conditions of issue and is coverage portable?***

- The Federal Health Insurance Portability and Accessibility Act (HIPAA) provided Americans with increased access to health insurance.
- Will the coverage offered under the proposal change an individual's HIPAA right to insurance without a pre-existing condition exclusion?
- Does the proposal contain open enrollment periods with guaranteed issue?
- What conditions, such as pre-existing condition exclusions, waiting periods, etc. will apply to uninsured individuals who wish to obtain coverage under the program?
- Will those who are already insured but want to move into the new program be subject to any pre-existing condition exclusions, waiting periods, etc.?
- If coverage eligibility is tied to certain requirements, such as being unemployed, are there any portability opportunities so coverage can be retained?

### **What Is the Benefit Package?**

The benefit package must be considered when evaluating proposals to provide health insurance coverage for the uninsured. Most insurance typically protects against catastrophic losses that occur with low probability. Employer-provided health insurance, however, has usually covered not only the expenses associated with high-severity, low-incidence health services, such as hospitalization, but also high-incidence, low-severity health services, such as office visits. One recent trend has been to move toward higher deductibles, thus reducing or eliminating coverage for more predictable health expenses. Another trend has been for some states to allow "bare bones" policies, thus avoiding state coverage mandates that can increase premium costs.

<sup>1</sup>For more information on who the uninsured are, see the American Academy of Actuaries issue brief *Health Coverage Issues: The Uninsured and the Insured*, which is available on the web at [http://www.actuary.org/pdf/health/uninsured\\_0903.pdf](http://www.actuary.org/pdf/health/uninsured_0903.pdf).

***What is the benefit design?***

- Does the proposal provide comprehensive coverage with relatively low deductibles similar to traditional health insurance, or does it provide benefits more closely associated with catastrophic coverage?
- Will coverage abide by state-mandated benefit requirements or are “bare bones” policies allowed?
- Is any required provider network adequate to meet the health care needs of plan enrollees?
- How flexible is the benefit package to advances in medicine?
- Does the benefit design include cost-sharing provisions designed to encourage efficient use of health care?
- Will the benefit design allow an individual to pre-fund future insurance expenses (e.g., health reimbursement accounts)?

***What Are the Costs to Individuals/Families?***

Many proposals to increase insurance coverage rely, at least in part, on the private insurance market. To make coverage in this market more affordable, proposals often provide subsidies that cover all or part of an individual’s insurance premiums.

***Are premium subsidies proposed?***

- What are the premium subsidy levels? Are they expressed as a percentage of premiums or as a flat amount?
- How do the subsidies vary by income or age? Do subsidies vary by income levels of the individuals within a state, or nationwide?
- Will they reflect state premium variations?
- How will the subsidies be distributed?
- Will they be provided in advance, as a refund of costs, or both?
- Where can individuals use their subsidies? Can they be used toward only one coverage plan, or toward any appropriate coverage the person may be eligible for?

***What are the net costs payable by individuals/families?***

- The cost of participating in an insurance plan includes not only the premium, but also any cost-sharing requirements. On one hand, high cost-sharing requirements will reduce premiums, all else being equal. On the other hand, some individuals, especially those with low incomes, may choose not to enroll in plans with high cost-sharing requirements, even if the premium would otherwise be affordable.
- What is the premium required, net of any subsidies?
- What is the deductible and are there any other cost-sharing requirements? Are there any cost-sharing subsidies for low-income individuals/families? Is alternative care available at no, or low, cost?
- Is there an out-of-pocket maximum that limits the amount of cost sharing?
- Are there any lifetime or annual benefit maximums? Are there any financial penalties imposed for not having coverage in place?

***Will insureds know the true costs of their health care?***

Insurance shields most Americans from the true costs of their health care. Workers who obtain insurance through their employer typically pay only part of the premium, and may not know the total premium costs, including the employer premium share. Perhaps even more important, when receiving health care services, insured Americans typically see only their out-of-pocket costs, not the total costs billed or paid. Some data suggest that the lack of understanding regarding the total costs of care provides insureds with incentives to over utilize health services.

- Will the proposal make insureds more aware of the total costs of their health care?
- Does the proposal include incentives intended to encourage insureds to be more efficient users of health care services?

***What Is the Cost to Employers?***

Although most insured Americans obtain their coverage through the workplace, the majority of the uninsured are in working families. Some employers, especially small employers, do not offer insurance. Moreover, many employers who do offer and subsidize coverage are responding to growing coverage costs by shifting more costs to workers through increased premiums or cost sharing, thus making it more expensive for workers. Many proposals aim to increase the share of employers offering coverage as well as increase the affordability of that coverage. Such proposals may include providing additional tax subsidies to employers offering coverage, man-

dating that employers offer coverage, providing reinsurance to employers to lower the costs of coverage, and facilitating the formation of purchasing pools for small employers. Whether such provisions would be successful at increasing the availability of employer-sponsored coverage and, ultimately, whether they will reduce the number of uninsured depends on several issues:

***Are tax subsidies available to employers who sponsor coverage?***

Currently, employers who offer insurance coverage are allowed to deduct their premium contributions as a business expense.

- Would any additional subsidies be available for employers who offer coverage?
- Would employers be required to pay a minimum share of the premiums to qualify for the subsidies?
- Would the subsidies apply to the costs for all workers, or would they be limited to those with low incomes, or other targeted populations?
- What conditions, if any, are placed on the availability of additional subsidies? For instance, are certain benefits required? Are minimum enrollment targets included? Are employers required to pass along any premium savings due to subsidies to the employees?

***Does the proposal include other provisions designed to make it easier for employers to offer coverage?***

- Does the proposal allow collective employer actions, such as purchasing pools or association health plans (AHPs)?<sup>2</sup>
- Will reinsurance be made available to reimburse employer plans for high-cost individuals?
- Does the proposal include some form of coverage sharing that would form a partnership among the employer, the government, and the insured?
- Note that the potential impact of some of these types of provisions on the insurance market is discussed in the next section.

***What are the estimated net costs to employers and are they predictable over time?***

- What are the premium costs to an employer affected by the proposal, net of any subsidies? Are they higher or lower than those currently available?
- What are the associated administrative costs? Are they higher or lower than current administrative costs?
- Are premium costs more predictable over time?
- Are there any costs for employers who do not offer coverage, or otherwise do not participate in the proposal?

***Are new subsidies available for insurance outside the employer group market?***

Proposals that increase the availability or affordability of insurance outside the employer group market could also impact whether some employers continue to sponsor coverage, regardless of whether any changes are made to the employer market. For instance, if subsidized insurance is available in the individual market, some employers may be less inclined to offer coverage to their workers.

- Does the proposal increase the availability or affordability of coverage outside the employer group market?
- Could the proposal prompt some employers to discontinue offering coverage for workers and/or their dependents? Is this consistent with the long-term goals of the proposal?
- Does the proposal include any incentives for employers to continue offering coverage?
- If workers can use individual tax credits to pay for their share of employer-sponsored coverage premiums, will employers shift more of the premium costs to workers?

**How Will the Proposal Impact the Health Insurance Market?**

***How will the proposal affect the different private insurance market segments (small group, large group, and the individual market)?***

There is not a single unified market for private health insurance. The three main segments are: large (employer) group, small (employer) group, and individual. There

<sup>2</sup>For more information on AHPs, please refer to the Academy's April 28, 2003 letter to Congress regarding the Small Business Fairness Act of 2003 (H.R. 660 and S. 545), which is available on the Academy's website at [http://www.actuary.org/pdf/health/ahp\\_042803.pdf](http://www.actuary.org/pdf/health/ahp_042803.pdf).

are major differences in the underwriting and pricing of the coverage in these three markets. These differences are due to competition, the regulatory environment (primarily state), and to the fundamental purchasing decisions made in the different markets.

Large-group insurance (generally over 50 employees) is driven more by competition than by regulation, at least in the underwriting and pricing functions. Insurers generally accept any employer and provide coverage to any enrolled employee or family. Prices are set at the group level and typically are based in whole or in part on the prior and expected medical costs of the specific group. An average price is charged for each employee and family unit, without variation for age, gender, or health status. Larger employers often self-insure the underwriting risk. State benefit and coverage mandates apply to the insured groups but not to the self-insured groups due to exemption under the Employee Retirement Income Security Act of 1974 (ERISA).

Small-group insurance (2 to 50 employees) is subject to significantly more state regulation of the rating and underwriting practices. All groups and eligible employees must be offered coverage regardless of health status. Surcharges based on health status for individual employees are not permitted. Premiums charged for each employee may be either the average of the group or based on the age and gender of the specific employee. Some states mandate community rating, whereby an insurer is required to pool the medical cost experience of all small groups in determining the expected average medical costs and premiums. The average rates serve as the basis of the rates charged to a specific employer. State variations often set limits on the maximum or minimum difference from this average, and also on the percentage rate increase an employer must pay in a given year due to experience. For example, the minimum may be 75% of the average, the maximum may be 150%, and the rate increase limit is the increase in the average plus 15%.

The individual insurance market is tightly regulated. Rating practices permitted by the states vary from community rating to full age/gender rating with initial underwriting loads (extra premiums) permitted. Many states permit individuals to be denied coverage due to poor health, or to have specific pre-existing conditions excluded for the life of the policy. Other states require that all applicants be accepted and all conditions covered. In most states, renewal rate change to reflect the change in an individual's health status is not permitted. However, the rates for the entire pool, both new and renewal business, may be increased to reflect the experience of the pool. A sub-segment of the individual market is composed of those who are guaranteed coverage regardless of health. In some states the entire market is guaranteed issue. This guaranteed issue right comes under the state group conversion regulations or under the federal HIPAA portability provisions. Although coverage must be offered to these individuals, the premium rates charged are typically higher than the rates for underwritten individuals. The excess premium charges may or may not be regulated by the state.

- Does the proposal change the underwriting methodology allowed in the different markets?
- Does the proposal increase or decrease the risks to be borne by any of the private market pools?
- Does the proposal change any ERISA exemptions for employers that self-insure coverage?
- Does the proposal give flexibility to both the insured and the insurer to provide products appropriate to the risk the insured wants to cover?
- Will the proposal allow insureds to move between markets?

***Will the proposal affect the risk composition of the insured population?***

Different insurance expansions can affect the insured-risk composition of the market differently. Proposals that remove the high-cost or otherwise uninsurable population from the individual and group markets and put them into a high-risk pool will reduce the coverage costs of the remaining population. The resultant lower premiums could make insurance more affordable among some of the currently uninsured. Similarly, if reinsurance is provided to insurers to cover the costs of high-cost enrollees, premiums could be reduced. Note, however, that such high-risk pools and reinsurance arrangements are mechanisms to spread cost, not eliminate it, and will reduce premiums only to the extent they are financed by a population broader than the privately insured population.

On the other hand, if healthy individuals are more likely to drop one type of coverage for another, premiums for those remaining with the original coverage will increase. Some may find the higher premiums unaffordable, and drop coverage as a result. Insurance plans that are left with a disproportionate share of unhealthy individuals are much less likely to be viable in the long term, which could ultimately

result in more uninsured individuals if those dropping coverage are unable to find more affordable coverage elsewhere.

- Does the proposal include high-risk pools, and if so, how are they financed?
- Does the proposal provide reinsurance to cover the costs of high-cost enrollees, and if so, how is it financed?
- Other than into high-risk pools, will the proposal result in healthier individuals opting for one type of plan and unhealthy individuals opting for another? If so, is this the desired result?

***Is adverse selection manageable?***

Sustaining a viable private health plan typically requires minimizing adverse selection, which occurs when relatively fewer healthy individuals enroll in a plan. However, this adverse selection is the norm in a high-risk pool. Therefore, it is important to consider the health characteristics of those who will become newly insured. In particular, will only the unhealthy choose to participate, or will the healthy participate as well? If this segmentation occurs, is it planned for in the proposal? Under a private group type plan the key to minimizing adverse selection is to increase participation, especially among healthy individuals. This can be accomplished through various means, including high premium subsidies, automatically enrolling eligible participants, and requiring higher premiums and/or other penalties for those who delay enrollment.

- Do insurance subsidies or other incentives encourage enrollment among not only the unhealthy but also the healthy?
- Does the proposal require the individual to obtain coverage?
- Does the proposal require an employer to provide coverage?

***Are risk-sharing provisions included?***

In the absence of universal coverage, some degree of adverse selection is inevitable and should be planned for. Risk adjustment and/or other types of reinsurance arrangements can reduce the incentives an insurer might have to avoid enrolling high-risk individuals. For instance, risk adjustment would adjust the payments to insurance plans to account for the health status of plan participants. As mentioned above, reinsurance is another option to limit insurers' downside risk. Under aggregate reinsurance, all or a percentage of a plan's total claims exceeding a predetermined threshold would be reimbursed. Individual reinsurance can reimburse a plan for high claims from individual plan participants.

- Does the proposal include risk adjustment to reduce the incentives among insurers to avoid high-risk individuals?
- Are reinsurance provisions included?

***What Are the Costs to States?***

Medicaid and coverage under the State Children's Health Insurance Program (SCHIP) are not reaching all the people they are designed to serve for many reasons. With state budget deficits increasing, states may have modified their Medicaid and SCHIP programs to reduce costs. These cost reductions have been in the form of increased eligibility requirements or the termination of eligibility categories, decreased benefits or provider fee schedules, and more aggressive contract negotiations with managed care plans that may administer a state's Medicaid or SCHIP program. Managed care plans may in turn withdraw from providing Medicaid or SCHIP coverage.

- Will the proposal increase Medicaid or SCHIP coverage through increased benefits, provider fee schedules, decreased eligibility requirements, or new eligibility categories?
- Will the proposal increase or decrease the financial burden to states and the federal government?

***Will enrollment in public programs increase?***

Implementing broader outreach programs to reach those who are eligible for public programs but do not know it may decrease the current number of uninsured.

- How does the proposal address bringing greater awareness of Medicaid and SCHIP programs to those who are eligible?
- Will administrative language and cultural barriers be reduced so that Medicaid and SCHIP enrollment will be more efficient and effective?

***What Is the Impact on Regulation?***

Individual states are responsible for regulating the individual, small—and large-group insurance markets and monitoring the financial solvency of insurance companies. ERISA controls many aspects of self-funded programs provided by larger employers.

- Will the proposal affect each state's ability to regulate its local insurance market?
- Will the proposal reduce or increase an individual state's regulatory burden?
- Which states will have to increase/decrease their regulatory activities as a result of the proposal?
- Will ERISA need to be modified to allow any changes required under the proposal?
- Can the federal government handle any new requirements?

***How Will the Proposal Be Funded?***

Proposals that include public program expansions or subsidies for private insurance coverage will need to be funded by state and/or federal revenues. Consideration of funding sources should also include an analysis of the sustainability of the funding over a relevant period of years and the proposal's impact on administrative costs.

***How will funding be provided?***

- Federal government
- State governments
- Individuals (e.g., taxpayers, program participants, uninsured, etc.)
- Employers (e.g., insured, self-insured, not currently offering insurance, etc.)

***Will funding be on an annualized basis or will it include long-term funding mechanisms?******What Is the Impact on Overall Health Costs?***

According to the Centers for Medicare and Medicaid Services (CMS), the United States spent \$1.6 trillion on health care in 2002 or 14.9 percent of gross domestic product (GDP). CMS projects spending to increase to \$3.4 trillion, or 18 percent of GDP, by 2013. Because rising health expenditures have contributed to insurance being less affordable and less available, managing the growth in health care costs is key to long-term solutions for reducing the number of uninsured. Medical malpractice reform, better contract negotiations with health care providers, more consumer awareness of the cost of healthcare, and others have all been suggested as potential ways to stem this growth.

- How will the proposal address the rising costs of health care?

***Conclusion***

Whether a proposal to reduce the number of uninsured is successful depends on many factors. We have tried to present many, but by no means all, of the issues that need to be considered as Congress drafts and evaluates proposals to extend health insurance coverage to the uninsured. Addressing these issues will improve the likelihood that such proposals will have a significant affect on reducing the growing number of Americans who lack health insurance coverage.

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**Statement of the American College of Physicians**

The American College of Physicians (ACP), representing more than 115,000 internal medicine physicians and medical students, is the nation's largest medical specialty organization and second largest medical association. The ACP commends Chairwoman Nancy Johnson for addressing the causes and consequences of lack of health insurance. Understanding who the uninsured are and why they lack health insurance is a critical first step to formulating policies that ensure this increasing segment of the population can access quality health care.

The advanced science, technology, and practice of American medicine is admired throughout the world. Americans with access to health care benefit from widely available preventive care, state-of-the-art equipment, and accomplished practitioners. However, the benefits of American medicine are less available to those who lack health insurance coverage. Individuals without health insurance coverage are less likely to have a regular source of care, more likely to delay obtaining needed



medical care until a later and more advanced stage of disease, and more likely to obtain care in more costly emergency centers rather than in a physician's offices. For these patients, the benefits of the best medical services in the world are not fully realized.

#### *Rising Numbers of Uninsured Americans*

Tough economic times and soaring health care costs have compromised access to the health system. As unemployment rises, states cut back on the number of people eligible for public insurance programs. At the same time, employers reduce benefits, shifting a larger share of health care costs to employees, or simply discontinue offering health insurance coverage. After increasing by roughly a million people each year throughout most of the 1990s, the number of uninsured now exceeds 43 million persons, representing more than 17 percent of the U.S. population under age 65.<sup>1</sup> Those most likely to lack health insurance continue to include young adults in the 18-to-24-year-old age group, people with lower levels of education, people of Hispanic origin, those who work part-time, and the foreign born.

#### *Health Consequences of Being Uninsured*

A popular myth exists that not having health insurance is merely an inconvenience. The myth asserts that anyone can go to an emergency room or free clinic and get care. To help dispel this myth and prove that lack of health insurance is a serious health threat, ACP conducted a literature review of over 1,000 documents published over the last ten years linking health insurance coverage with the utilization of health care services and individual health outcomes. The College's 2000 report, *No Health Insurance? It's Enough to Make You Sick*, verified that the uninsured experience reduced access to health care and tend to live sicker and die younger than people with health insurance. Evidence from the available medical and scientific literature indicates that:

- Uninsured Americans experience reduced access to health care;
- Uninsured Americans are less likely to have a regular source of care;
- Uninsured Americans are less likely to have had a recent physician visit;
- Uninsured Americans are more likely to delay seeking care;
- Uninsured individuals are more likely to report they have not received needed care;
- Uninsured Americans are less likely to use preventive services;
- Uninsured Americans experience poorer medical outcomes;
- Uninsured Americans experience a generally higher mortality and a specifically higher in-hospital mortality;
- There is a disproportionate representation of racial and ethnic groups among the uninsured;
- Uninsured Americans may be up to three times more likely than privately insured individuals to experience adverse health outcomes;
- Uninsured patients are up to four times as likely as insured patients to require both avoidable hospitalizations and emergency hospital care.

More specifically, ACP found that uninsured working-age adults are:

- More likely to go without care that meets professionally recommended standards for managing chronic diseases, such as timely eye exams to prevent blindness in persons with diabetes;
- Less able to access medications needed to manage conditions like hypertension or HIV;
- Less likely to receive appropriate cancer screening, resulting in delayed diagnosis, delayed treatment, and premature mortality; and
- More likely to have avoidable medical crises and emergency hospitalizations from untreated conditions.

A separate study, funded by ACP to raise awareness about the uninsured found that high proportions of uninsured adults were not receiving needed medical care. The study examined 1997 and 1998 survey data for more than 220,000 adults between the ages of 18 and 64 from the Centers for Disease Control and Prevention's Behavioral Task Force. Highlights from this study, which was published in the *Journal of the American Medical Association*,<sup>2</sup> include:

<sup>1</sup> U.S. Census Bureau. Current Population Reports: Health Insurance Coverage in the United States: 2002. September 2003.

<sup>2</sup> Ayanian J, Weissman J, Schneider E, Ginsburg J, and Zaslavsky A. Unmet Health Needs of Uninsured Adults in the United States. *JAMA*. October 2000; 284 (16): 2061—2069.

- About 14 percent of respondents lacked health insurance and 10 percent had gone without health insurance for an entire year.
- Nearly two-fifths of long-term uninsured and one-third of short-term uninsured adults reported they were unable to see a physician within the last year due to costs.
- Of the long-term uninsured, nearly 70 percent of those in poor health and nearly 50 percent of those in fair health reported being unable to see a physician in the previous year due to cost.
- Those who reported excellent or very good health were two to three times more likely to have health insurance.
- For highly recommended preventive services, long-term uninsured adults (those that were without health insurance for more than one year) were three and a half times less likely to receive cardiovascular risk reduction services such as hypertension and cholesterol screening; 25 percent less likely to have had a mammogram; and three to four times less likely to have had a screening for breast cancer.
- Clinical risk groups for the long-term uninsured reported being unable to see a doctor when they needed due to cost during the past year including: 37 percent of smokers, one-third of the obese, 40 percent for hypertension, 46 percent of diabetics, and 37 percent with elevated cholesterol.
- One in five of the short-term uninsured in these same risk groups reported encountering the same obstacles.
- One quarter of the long-term uninsured had not received a routine check up in the last two years in high-risk groups reporting hypertension, diabetes and elevated cholesterol.
- Nearly half of the long-term uninsured women and 40 percent of short-term uninsured women reported being unable to see a doctor when needed during the last year (versus 30 percent and 22 percent of men.)
- Long-term uninsured women aged 50–64 were three times less likely than insured women of the same age to have received a mammography or clinical breast exam; long-term uninsured women between ages 18 and 64 were three times as likely not to have obtained a pap smear within the last three years.
- Nearly 20 percent of the self-employed had been uninsured for greater than one year; another 5 percent had been without insurance for some period within the last year.
- Nearly 40 percent of the employed long-term uninsured and 30 percent of the employed short-term uninsured reported being unable to see a doctor when needed during the last year.
- In contrast to federal and state government efforts to extend affordable health care coverage to children, nearly 33 million adults continued to lack a cohesive plan to address their needs.

#### *Economic Costs of Being Uninsured*

One of the principal obstacles to enactment of legislation to expand health insurance coverage to all Americans is the belief that the cost would be enormous and unaffordable. In a forthcoming paper, *The Cost of the Lack of Health Insurance*, ACP documents the extent of what is known about the aggregate economic costs to the United States of maintaining a considerable uninsured population. By illustrating that the United States already spends an enormous amount on health care for the uninsured, both in terms of the direct costs of services provided and the indirect costs to society of having individuals forego or delay receipt of needed health care, the paper counters the claim that the cost of extending coverage to the uninsured is prohibitive.

Following an extensive review of the current literature, ACP found that the most integral cost estimate of the uninsured takes into account multiple factors, some more quantifiable than others. There are the direct costs borne by the health care system for treating the uninsured, whose care is often more expensive than the insured since the uninsured tend to receive treatment in the emergency department and lack preventive care. These costs must be absorbed by providers as free care, passed on to the uninsured via cost shifting and higher health insurance premiums, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs. Estimates of the direct costs of the uninsured found in the literature include:

- The uninsured receive as much as \$98 billion in medical care, \$35 billion of which is considered uncompensated, a year.
- Total government spending in the name of the uninsured is about \$30 billion a year.
- Hospitals provide about \$24 billion worth of uncompensated care a year.

- Physicians spend about \$5.1 billion a year caring for those who cannot pay their bills.
- Employers and managed care companies spend \$1.5-\$3 billion through higher rates to cover part of the amount hospitals spend caring for the uninsured.<sup>3</sup>

Although the indirect costs associated with lack of insurance are more difficult to calculate, a discussion of the consequences of not extending coverage to the uninsured would be incomplete without their consideration. Inadequate preventive care and delayed treatment among the uninsured yields substantial societal costs in terms of reduced life expectancy, lower workforce productivity, diminished educational attainment, imperiled public health, and the financial burden shouldered by uninsured individuals and communities. Making preventive medicine and existing treatment therapies available to uninsured persons will not only increase overall access to health care but may also substantially contribute to a reduction in the total burden of illness facing the United States.

The Institute of Medicine (IOM) report, *Hidden Costs, Value Lost*, estimates the aggregate, annualized cost of diminished health and shorter life span to be between \$65 billion and \$130 billion for each year of health insurance forgone. This figure does not include the increased financial risk and uncertainty borne by the uninsured and their families, which is estimated to cost between \$1.6 billion and \$3.2 billion, nor does it account for the wide range of societal costs to which a price tag cannot be assigned.<sup>4</sup>

Critics of proposals to expand health insurance coverage point to the high cost of the additional medical care that would be used by newly insured Americans if coverage were expanded. However, a report published in *Health Affairs* in June 2003, found that this amount may not be as high as critics claim. The authors estimated that the uninsured would use about \$34-\$69 billion (in 2001 dollars) in additional medical care if they were fully insured, accounting for about 3-6 percent of total health care spending. While this amount may seem large in absolute dollars, an increase in medical spending of this range would increase health care's share of gross domestic product (GDP) by less than one percentage point.<sup>5</sup>

In a related analysis, the IOM found the estimated benefit that the uninsured would experience from incremental health coverage (\$1,645 to \$3,280) to be higher than the estimated incremental cost of providing that service to the uninsured (\$1,004 to \$1,866), resulting in a benefits-cost ratio of at least one for most values within each range.<sup>4</sup> Given the positive effects health insurance has on life expectancy, public health, educational attainment, production, and the economy in general, the benefits of extending coverage to the uninsured appear to be greater than the costs of not insuring them.

The value of extending health insurance coverage to all Americans requires an understanding of the alternative—the cost of leaving over 17 percent of the population under age 65 uninsured for all or part of the year. When millions of Americans are unable to receive the care they need, the health and lives of all patients are endangered, costs are added to the health care system, and productivity is reduced. In the debate of how to extend coverage to the uninsured, it is critical that both short and long-term benefits are fully considered, since the latter may offset what many critics fear are the direct costs associated with such an expansion.

#### *Proposals to Expand Health Insurance Coverage*

Given that the rising number of uninsured are imposing huge economic and social costs on our country, ACP believes that it is essential that Congress enact legislation to expand health insurance coverage to all Americans by the end of the decade, starting with the working poor and near poor who do not qualify for coverage under public safety net programs and those who do not have access to affordable employer-provided and individual insurance. In April 2002, ACP proposed a plan, entitled "Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists," which offers a framework for policies that would enable all Americans to obtain affordable health insurance within seven years. The College's plan calls on Congress to take the following steps:

Enacting legislation to make affordable coverage available to all people with incomes up to 200 percent of the Federal Poverty Level (FPL), including: creating a national income eligibility for Medicaid at 100 percent of FPL; converting the State

<sup>3</sup> Hadley J, Holahan J. How Much Medical Care Do the Uninsured Use, and Who Pays For It? *Health Affairs* Web Exclusive. 12 February 2003.

<sup>4</sup> Institute of Medicine. *Hidden Costs, Value Lost*. Consequences of Uninsurance Series, No. 5. Washington, DC: National Academies Press; 17 June 2003.

<sup>5</sup> Hadley J, Holahan J. Covering the Uninsured: How Much Would It Cost? *Health Affairs* Web Exclusive. 4 June 2003.

Children's Health Insurance Program (CHIP) to a federal-state entitlement program; and creating a tax credit/premium-subsidy program for individuals from 100–200 percent of FPL that would apply to Medicaid or SCHIP “buy-ins” or toward the purchase of private insurance.

- Expanding the premium subsidy program to uninsured people with incomes above 200 percent of FPL, while authorizing the creation of purchasing groups and conditions for health plan participation, modeled after the Federal Employees Health Benefit Program.
- Enacting legislation to authorize states to request a waiver to opt-out of the national framework for coverage. States that meet federal guidelines would be able to use federal funding for state programs.
- Establishing a national commission that would report annually to Congress on progress, develop a basic benefits package, and recommend mechanisms to discourage individuals from voluntarily opting out of insurance coverage.

Key elements of the College's seven year plan subsequently have been incorporated into the bipartisan Health Coverage, Affordability, Responsibility and Equity Act of 2003 (HealthCARE Act of 2003), H.R. 2402, introduced by Rep. Steve LaTourette (OH) and Marcy Kaptur (OH). A companion bill, S. 1030, has been introduced in the Senate.

We believe that the policy framework proposed in the HealthCARE Act of 2003 provides a realistic basis for a bipartisan consensus in Congress on expansion of health insurance coverage. The legislation provides for a program of tax credits combined with state purchasing pools, to provide uninsured low-income Americans with the same dollar subsidies and choice of health plans available to members of Congress and other federal employees through the Federal Employee Health Benefits Program. It provides a means for small businesses to band together to purchase coverage comparable to that available under the FEHBP. It also provides states with new options to expand and simplify enrollment on Medicaid, without imposing new unfunded mandates on the states. Finally, it provides an innovative structure to encourage health plans to offer essential health benefits without imposing unrealistic benefit mandates. The ACP would welcome the opportunity to provide additional information to the Committee on the HealthCARE Act of 2003 and on initial steps that could be taken this year, based on elements in this legislation, to expand health insurance coverage to the working poor.

#### *Conclusion*

The American College of Physicians appreciates the opportunity to provide the Ways and Means Committee's Subcommittee on Health with this summary of our views on the economic and health costs of not providing health insurance coverage to 44 million Americans, as well as our recommendations for expanding coverage to all Americans. Additional information on ACP's analysis and proposals can be found on our website:

- **No Health Insurance? It's Enough to Make You Sick:** <http://www.acponline.org/uninsured/lack-contents.htm>
- **Unmet Health Needs of Uninsured Adults in the United States:** Ayanian J, Weissman J, Schneider E, Ginsburg J, and Zaslavsky A. Unmet Health Needs of Uninsured Adults in the United States. JAMA. October 2000; 284 (16):2061–2069.
- **Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists:** [http://www.acponline.org/hpp/afford\\_7years.pdf](http://www.acponline.org/hpp/afford_7years.pdf)
- **The Cost of the Lack of Health Insurance:** <http://www.acponline.org>
- **Highlights of the HealthCARE Act of 2003, H.R. 2402, S. 1030:** [http://www.acponline.org/uninsured/bing\\_highlights.pdf](http://www.acponline.org/uninsured/bing_highlights.pdf)
- **Section by Section Summary of the HealthCARE Act of 2003,** [http://www.acponline.org/uninsured/bing\\_sectsum.pdf](http://www.acponline.org/uninsured/bing_sectsum.pdf)

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#### **Statement of Associated Builders and Contractors, Arlington, Virginia**

##### **SPEAKING FOR THE MERIT SHOP**

Associated Builders and Contractors (ABC) appreciates the opportunity to submit the following statement for the official record. We thank Chairwoman Nancy Johnson (R-CT), Ranking Member Fortney “Pete” Stark (D-CA) and members of the

Health Subcommittee of the House Ways and Means Committee for addressing the crisis of the uninsured in America. ABC urges the committee to follow up on this important hearing with an additional hearing to examine possible solutions to this growing epidemic.

ABC is a national trade association representing 23,000 general contractors, sub-contractors, material suppliers, and construction-related firms from across the country within a network of 80 state chapters. Our member companies represent over one million craft professionals and administrative employees. As the nation's second-largest employer, with over 6 million workers, the construction industry continues to create new and beneficial jobs each year. Construction spending has a stimulative effect on the economy. For every \$1 million spent in construction, \$3 million in economic activity is generated and 13 new permanent jobs are created.

To remain at the present level of activity, the construction industry needs an additional quarter of a million (250,000) workers per year to replace an aging and retiring workforce. One of the key elements to attracting and retaining workers and remaining competitive in any industry is to provide high quality, flexible health benefit plans. Providing quality health care benefits is a top priority for ABC and its members, and maintaining cost effective health insurance plans is a key ingredient in achieving this objective.

Currently, there are more than 43 million uninsured Americans, and 60 percent of them are employed by (or family members are employed by) small businesses. Therefore, the problem of the uninsured does not solely lie with the unemployed, but also with the small businesses across the country who are unable to provide quality health care coverage due to skyrocketing costs. In fact, a new study by the Robert Wood Johnson Foundation found that more than one in three Americans under 65 was uninsured at some point over the past two years.

In 2002, the Census Bureau released a study that showed that the share of the population covered by employer-sponsored health care coverage declined from 63 to 61 percent. The rising cost of health insurance premiums is the biggest factor in this decline and number one problem facing small business in this country. Faced with 15, 20 and even 50 percent premium increases annually for the past several years, many small businesses have been forced to reduce or even drop coverage.

Many factors have contributed to the cost increase of health insurance. Hospital costs, frivolous medical malpractice lawsuits, lack of competition and increased state regulation have all led to increased premiums. However, it is important to note that while health insurance costs have gone up at twice the rate of inflation, a vast majority of small businesses's productivity and profits have failed to grow at the same rate. One sector though, has enjoyed its greatest profit margins ever. The insurance industry, namely large health insurance companies, have experienced record-setting profits over the past few years.

A number of state reforms have actually led to increased rates, thus forcing employers to reduce benefits through higher deductibles and co-pays or eventually to drop coverage in order to comply with the law. State health insurance reforms and community rating laws have forced some insurance carriers to completely withdraw from the small group market for employers with less than 50 employees. When these and other state reforms occur, small employers are left with fewer alternatives for health insurance coverage for themselves and their employees.

Recent mergers of health insurance companies have also reduced competition and alternatives for employers who seek access to quality and affordable health insurance. Today, there is a great need to bring more competition back into the system rather than continually reducing it.

While there is no single solution to the problem of the uninsured, ABC feels that it is vital for Congress to examine the current market and to consider proposals that will provide market-based reforms. We believe that our current health insurance system, while flawed, is still the best in the world. Any solutions should help provide working families the best opportunity to obtain the quality, affordable health coverage they both need and deserve. Increasing competition within the small group market will help lower costs to employers struggling to continue to offer health insurance to their employees today.

The House of Representatives has already passed The Small Business Health Fairness Act (H.R. 660), which represents one common-sense proposal to address the uninsured problem plaguing small businesses. President Bush, a strong proponent of this legislation, called on the Senate to pass this same measure in his State of the Union Address. ABC recognizes the need for this legislation and commends the House for approving it last summer.

ABC appreciates this opportunity to submit comments on such a vital issue. We look forward to continuing a constructive dialogue on how to increase access to af-

fordable and competitive health insurance for small businesses and thus reducing the number of uninsured Americans.

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**Statement of Michael D. Place, Catholic Health Association of the United States**

**THE NATIONAL TRAGEDY OF THE NEARLY 44 MILLION UNINSURED**

**INTRODUCTION**

Clearly, a disease that infects nearly 44 million individuals in this country would quickly command resources from every possible governing agency and public health entity. But this country faces an epidemic of uninsured individuals, and many in our nation seem willing to ignore this epidemic.

While researchers and economists may disagree on exactly how many are uninsured, their income levels, and the reasons that they are uninsured, no one can deny the fact that by default a **“silent” national policy excludes 1 in 7** individuals from fully participating in and enjoying the benefits of our health care system.

The recent IOM Study, *Insuring America’s Health: Principles and Recommendations*, and numerous other research reports clearly state that being uninsured presents a formidable barrier to obtaining necessary medical care with a multitude of health consequences. For the individual, treatment delayed can mean serious complications, even death. For society, it means the potential spread of disease, rising medical costs, and the inefficient expenditure of health care resources.

As the Catholic health ministry, whose history began over 275 years ago, we continue to serve uninsured and underinsured individuals every day in our hospitals and clinics. We have seen the unraveling of our nation’s safety net due to a downturn in our nation’s economy; decreasing resources at the local, state, and federal level; and increasing demands for services. The strains on our health care system must be addressed.

As employers, health care providers, and above all as a community of faith, our values are the basis for our commitment to addressing these issues and presenting our recommendations.

**OUR VALUES**

The perspective of the Catholic health ministry is founded in social justice teachings. The following are our “operating principles,” derived from a faith-based tradition of caring for the poor, healing the sick, and speaking for those who often go unheard.

- **Every person is the subject of human dignity.** This dignity must be honored, preserved, and protected from conception to death, whether one is disabled or aged. Flowing from this dignity is the right to basic and continuing health care.
- **Health care is a service to people in need.** Health care is an essential social good. It should never be reduced to a mere commodity exchanged for profit.
- **Health care must serve the common good.** The health care needs of each individual must be balanced by the needs of the larger society.
- **There is a special duty to care for the poor and vulnerable.** The well and the wealthy should care for the poor, the sick, and the frail.
- **There must be responsible stewardship of resources.** The resources needed for health care must be balanced with the needs of other essential social services.
- **Subsidiarity.** To the greatest degree practicable, administration must be carried out at the level of organization closest to those to be served.

Our ministry’s approach to health care rests in these values. As a result, we believe there is a human right to basic health care and that society has a special duty to care for the poor and vulnerable. These are commitments that many Americans, regardless of their denomination or faith, also share.

Today, turning a blind eye to discrimination, denying any child a public education, or allowing a defendant in a criminal proceeding to stand trial without legal assistance would be unacceptable to us as a nation.

We believe that if more individuals understood the suffering that millions among us endure, the apathy that now shrouds the issue of helping the nation’s uninsured could be remedied. After all, any one of us among the over 160 million privately insured could very quickly and unexpectedly join the ranks of the uninsured.

As a ministry, we continue to take steps to educate and raise awareness among our associates, our community leaders, and the general public about this critical issue. We are committed to partnerships with other organizations such as the Robert Wood Johnson Foundation to prepare this country for a serious dialogue about the nearly 44 million who are uninsured. We also are looking at innovative ways to provide coverage for low-wage earners in our own ministry, and to assist in identifying and facilitating enrollment of those populations who are eligible but not enrolled in public programs. Our ministry is motivated by our mission and underlying values to do the right thing, as evidenced through our commitment to broader community benefit efforts.

As we prepare for this national dialogue, the Catholic health ministry has articulated the following guiding principles for a broader approach to health care reform and remains committed, both in the short and long term, to achieving the necessary changes in our current system. The guiding principles include:

- A reformed system should provide health care for all
- A defined set of basic benefits should be available to all
- Responsibility for health should be shared by all
- Spending on health care should be based on the appropriate and efficient use of resources
- Financing of the delivery of health care should be adequate and based upon a pluralistic model, with shared responsibility by government, employers, and individuals
- A reformed system should provide quality health care services
- The effective participation of patients and families in decision making should be encouraged and enhanced

In light of our values and our guiding principals, we offer the following recommendations for your consideration.

#### RECOMMENDATIONS

There are tough moral, ethical, and policy questions surrounding the uninsured that must be discussed and debated in an open forum where all sides are heard. We thank the committee for addressing these very important policy questions.

Without abandoning the goal of accessible and affordable health care for all, but in recognition of the valuable lessons learned from previous efforts, CHA has chosen to pursue a strategy that works toward our goal in intentional and sequential steps.

Our proposal, crafted in collaboration with the American Hospital Association, is both an acknowledgment of today's political realities and an example of the policy choices and strategy we intend to follow in building an infrastructure for accessible and affordable health care for all. This proposal is consistent with our sense of societal responsibility and guiding principles. We are well aware of the current fiscal constraints at the local, state, and federal level, but we also believe that this issue demands significant resources in the near term.

While we acknowledge that this proposal is not the ultimate solution, and that accessible and affordable health care for all cannot be achieved overnight, we do believe that this proposal provides additional ideas and consideration for the committee as it looks for ways to craft bipartisan legislation that achieves coverage for our nation's children, the future of our country, and those most in need of care.

The AHA/CHA proposal would expand insurance coverage through a combination of approaches. **The proposal mandates that all children have health insurance coverage**, and expands eligibility under the Medicaid and State Children's Health Insurance Program (SCHIP) for those children not otherwise covered by other sources. The plan also would provide tax credits and premium subsidies to assist small employers and individuals in the purchase of private health insurance for their workers and families. The three key components to the AHA/CHA proposal to expand health insurance coverage are briefly described below.

**1. Mandatory Children's Coverage:** All children under the age of 19 would have coverage. Accessible and affordable health care for all children, without reducing employer coverage for dependents, would be accomplished by structuring the programs so that financial incentives remain for people to cover their children through private insurance whenever possible. Children would be enrolled at birth. Subsequently, coverage would be required as a condition of enrolling in school.

- *Premium Structure:* States would be required to expand eligibility under their Medicaid and/or SCHIP programs to provide subsidized coverage for all children living below 250 percent of the federal poverty level (FPL). Children below 150 percent of the FPL would be covered without premium contribution, while premiums would be phased in on a sliding scale for those between 150 and 250 percent of the FPL, subject to a premium cap equal to 5 percent of family in-

come. Children above 250 percent of the FPL would pay full actuarial costs in premiums to “buy into” the Medicaid/SCHIP coverage.

- *Benefits Package:* States would have the choice of offering the Medicaid benefits package or an alternative benefits package (similar to SCHIP).
- *FMAP:* State spending would be matched at the current SCHIP enhanced Federal Medical Assistance Percentage (FMAP) rate.
- *Eligibility:* States would be required to maintain their current income eligibility levels and covered services throughout the Medicaid/SCHIP programs.

**2. Small Employer Premium Subsidies/Tax Credits:** The plan includes premium subsidies to small employers for the purchase of insurance for low-wage workers below 200 percent of the FPL. The premium support would be administered by the United States Treasury Department.

- *Employer Eligibility:* Firms with between 1 and 50 workers would be eligible for the subsidies, provided the employer’s workforce is paid less than an average of \$10.00 per hour, or 60 percent of employees in the firm are earning less than \$10.00 per hour. In addition, the employer must be paying at least 70 percent of the premium for single-only coverage, and 60 percent of the premium for family coverage. The subsidies would be available to both for-profit and not-for-profit employers.
- *Subsidy Amount:* The maximum subsidy would be 50 percent of the employer’s share of the premium, up to a maximum premium amount based on a benchmark health plan (i.e., Blue Cross Blue Shield’s “Basic Plan” offered through the Federal Employees Health Benefits Plan). The premium percentage subsidy is phased down with firm size from 50 percent for the smallest firms to 30 percent for firms with 50 workers.
- *Additional Provisions:* The subsidy would be refundable (the amount of the subsidy could exceed the amount of taxes owed by the employer), and would be advance fundable so that subsidies are available throughout the year as the employer’s premium payments are due. In addition, employers taking the subsidy would be required to offset the employer premium payment by the amount of the subsidy received in determining the employer’s allowable deduction for employee health benefits costs.

**3. Premium Subsidies/Tax Credits for Individuals:** The program would provide a subsidy for the purchase of non-group insurance for people below 300 percent of the FPL, or help pay the worker’s share of premiums for people with employer-sponsored insurance (ESI).

- *Subsidy for individual non-group coverage:* The subsidy would be equal to two-thirds of the insurance payments for qualified coverage through an FEHBP plan, and would be phased out for persons over 150 percent of the FPL reaching \$0 at 300 percent of the FPL.
- *Subsidy for employee share of ESI:* The premium subsidy amount is capped not to exceed \$1,000 for single coverage and \$3,000 for family coverage for the employee share of the ESI.

## CONCLUSIONS

As provider, employer, advocate, citizen, bringing together people of diverse faiths and backgrounds, our ministry is an enduring sign of health care rooted in the belief that every person is a treasure, every life a sacred gift, and every human being a unity of body, mind, and spirit.

As the Catholic health ministry, our faith tradition calls us to collaborate with others to be both a voice for the voiceless—the millions of uninsured—and agents for change. CHA has been, is, and will continue to be a strong advocate for accessible and affordable health care for all in a reformed health care system. We stand ready and willing to work with the committee this year and as long as it takes to craft an equitable solution to this national tragedy.





Communicating for Agriculture and the Self-Employed  
 Fergus Falls, MN 56537  
 March 9, 2004

The Honorable Nancy Johnson  
 Chair, Subcommittee on Health  
 House Ways and Means Committee  
 Washington, DC 20515

Dear Chairman Johnson:

Communicating for Agriculture and the Self-Employed (CA) is a national, non-profit rural association made up of farmers, ranchers and rural small business members throughout the country. Throughout CA's 32-year history, we have been active on health care affordability and access issues and we applaud your efforts to address, through a series of hearings, this pressing problem for millions of Americans.

While much of the discussion on this issue has centered around the employer-based health insurance market, our members bring a different perspective to the issue, a perspective I would be happy to discuss at a future hearing. Many of our members are self-employed, do not have access to employer-based insurance and must rely on the individual health insurance marketplace.

Solutions that we have found that would help these individuals obtain affordable health insurance, and solutions I would be happy to discuss with the Subcommittee in future hearings, include:

#### **State Health Insurance High Risk Pools**

High risk pools are special state created and overseen health insurance programs that serve people in the individual market who have been denied coverage, or who can only access coverage at very high rates due to a pre-existing health condition such as cancer, congestive heart failure, diabetes, AIDS and other chronic illnesses.

Federal legislation recently provided \$40 million a year for two years to help existing risk pools and another \$20 million to help states form new pools. (CA was called in by the Department of Health and Human Services to suggest language for the new regulations governing this program.) CA is now supporting legislation that would increase the funding per year and extend the program through 2009.

#### **Advanceable, Refundable Tax Credits to Purchase Health Insurance**

As you know, there are several proposals in Congress to create an advanceable, refundable income tax credit for the cost of health insurance purchased by individuals under 65 years of age.

Depending on income and other factors, this tax credit would be available in advance of the time the insurance is purchased. Individuals would reduce their premium payment by the amount of the credit and the health insurer would be reimbursed by the Department of Treasury for the amount of the advance credit. Eligibility for the advance credit would be based on an individual's prior year tax return.

#### **Individual Tax Deductions**

In addition the refundable tax credits, CA supports 100 percent deduction for health insurance for all individuals and there are several bills now in Congress to address this issue. Businesses and the self-employed can deduct 100 percent of health insurance costs, but not individuals. If General Motors can deduct its insurance costs, why can't a woman who holds two part time jobs and is not eligible for health insurance at either job, deduct the cost of her individual policy?

We believe that there is no one silver bullet that will immediately solve the problem for our uninsured. However, we also believe that a combination of programs, such as those I have outlined, will go a long way to enable a great many more Americans to have access to health insurance.

Our members support your efforts to deal with this very serious and very complex problem and if we can ever be of service, please don't hesitate to call.

Thank you.

Sincerely yours,

Wayne Nelson  
*President*

### Statement of Marina L. Weiss, March of Dimes

The March of Dimes Birth Defects Foundation is pleased to submit for the hearing record the following statement on "The Uninsured."

President Franklin Roosevelt established the March of Dimes in 1938 to fight polio. The March of Dimes committed funds for research and within 20 years Foundation grantees were successful in developing a vaccine to prevent polio. The March of Dimes then turned its attention to improving the health of children through the prevention of birth defects, prematurity and infant mortality. As you might expect, providing coverage to women of childbearing age, especially those who are pregnant, infants and children are policy priorities for the Foundation.

Today, access to health insurance is especially pertinent to the advancement of the March of Dimes mission. In January 2003, the Foundation embarked upon a 5-year, \$75 million campaign to address the growing problem of preterm birth. The Prematurity Campaign is designed to increase awareness of the problem of preterm birth; to expand research on the causes of preterm birth and the care of babies born preterm; and to improve access to health coverage for women of childbearing age and their children.

The March of Dimes includes millions of volunteers and 1,400 staff members who work through chapters in every state, the District of Columbia and Puerto Rico. The Foundation is a unique partnership of scientists, clinicians, parents, business leaders and other volunteers, who work to advance the mission by supporting programs of research, community services, education and advocacy.

At the March of Dimes, the overarching goal is to improve the health of women and children. This is why we are so concerned about improving access to health coverage for women of childbearing age, especially those who are pregnant, as well as to their infants and children.

#### The Problem of the Uninsured

Lack of health coverage continues to be a significant problem for millions of Americans. The Census Bureau reported in September 2003 that 43.6 million Americans were uninsured in 2002. Census Bureau data commissioned by the March of Dimes show that **in 2002, 12.1 million women (19.6 percent) or nearly one in five women of childbearing age (15–44) went without health insurance**—a higher rate than other Americans under age 65 (17.2 percent). In other words, approximately 28 percent of uninsured Americans are women of childbearing age. Hispanic women in this age group are more than 2.5 times as likely as whites to be uninsured—37 percent compared to 14 percent respectively. Native American (29 percent), African-American (24 percent) and Asian (24 percent) women were also likelier than whites to be uninsured.

Compared with a U.S. average of 19%, New Mexico (31 percent) and Texas (30 percent) had the highest rates of uninsured women of childbearing age for the 2000–2002 period according to the U.S. Census Bureau.<sup>1</sup> Since the mid-1980's expanded Medicaid eligibility for pregnant women has resulted in better rates of coverage for this group than for women in general. The Congressional Budget Office, citing in part March of Dimes supported research, estimates that about 1.7 million pregnancies are covered each year through Medicaid.<sup>2</sup> But as the data indicate, considerable room for improvement remains.

#### Health Insurance Makes a Difference

Numerous studies have shown that having insurance coverage affects how people use health care services.<sup>3</sup> Particularly important is the finding that the uninsured are less likely to have a usual source of medical care and are more likely to delay or forgo needed health care services.

In a report issued in 2002 by the Institute of Medicine, researchers concluded that "[L]ike Americans in general, pregnant women's use of health services varies by insurance status. Uninsured women receive fewer prenatal care services than their insured counterparts and report greater difficulty in obtaining the care they believe they need."<sup>4</sup>

A study funded by the March of Dimes and cited by the Institute of Medicine in its report shows that, in 1996, some 18.1 percent of uninsured pregnant women re-

<sup>1</sup>U.S. Census Bureau, March 2003 Current Population Survey. Data prepared for the March of Dimes. October 2003. <http://www.marchofdimes.com/files/census2003.pdf>

<sup>2</sup>Congressional Budget Office. "Cost Estimate: S. 724 Mothers and Newborns Health Insurance Act of 2002." October 11, 2002.

<sup>3</sup>Kaiser Commission on Medicaid and the Uninsured. *Sicker and Poorer: The Consequences of Being Uninsured*. February 2003.

<sup>4</sup>Institute of Medicine. *Health Insurance Is A Family Matter*. National Academies Press. 2002.

ported going without needed medical care during the year in which they gave birth. That compares with 7.6 percent of privately insured pregnant women and 8.1 percent of pregnant women covered through the Medicaid program.<sup>5</sup>

Pregnancy represents a significant cost to young parents without insurance, even in the healthiest pregnancies. For families with a problem pregnancy, the financial impact can be devastating. Without access to health insurance, many pregnant women delay seeing a doctor and getting the prenatal care they need. As the report that accompanied legislation passed by the Senate Committee on Finance in the last Congress stated, “[R]ecent studies have shown that infants born to mothers receiving late or no prenatal care are more likely to face complications which can result in hospitalization, expensive medical treatments, and increased costs to public programs. Closing the gap in coverage between mothers and their children will improve the health of both, while reducing costs for taxpayers.”<sup>6</sup>

### **Maternity Coverage is Often Not Available in the Individual Insurance Market**

In accordance with its mission, the March of Dimes seeks to reduce the number of uninsured women, infants and children and to improve access to medical care. It is for this reason that the Foundation is concerned about certain aspects of Administration and Congressional proposals to address the problem of the uninsured by providing a health insurance tax credit for use in the individual market. A recent study by Ed Neuschler of the Institute for Health Policy Solutions, commissioned by the March of Dimes, found that using tax credits to subsidize the purchase of individual (non-group) health insurance would do little to expand access to maternity coverage.<sup>7</sup> Services related to normal pregnancy and childbirth typically are not covered under health insurance policies sold in the individual market—except in a few states where such coverage is mandated. In some cases, maternity coverage for individuals is offered as a separate rider with an additional premium. Coverage under such riders is typically very expensive and limited in scope, with separate higher deductibles or low dollar limits on benefits, and special waiting periods. Private individual coverage for women who are already pregnant is simply not available, at any price. In fact, to the extent that tax credits promote a shift from employer-based coverage to individual coverage, as some researcher predict, widespread use of such credits could increase the number of young families lacking coverage for maternity care, according to Neuschler’s report.

Maternity care is offered in most employer plans. Under the federal Pregnancy Discrimination Act, employers with 15 or more workers may not offer health insurance that excludes maternity care. Some researchers have estimated that, while providing tax credits for non-employment-based coverage would reduce the number of uninsured, there would be considerable shifting in source of coverage. That is, the number of individuals with employment-based coverage and associated maternity benefits would decline, mostly due to employers’ elimination of health coverage as a fringe benefit, with the result that some employees would switch to individual insurance and others would become uninsured. Thus, the number of people with individual coverage (and, therefore, without maternity coverage in most cases) could increase significantly. None of the individual health insurance tax credit proposals introduced in the 108th Congress would specifically require qualifying health plans to cover maternity benefits.

While several approaches to improve the availability of maternity coverage might be considered in the context of designing a tax credit, there appears to be no easy way to assure that a policy of subsidizing individual health insurance plans will also expand coverage of maternity care. Simply requiring health insurers to include maternity coverage in individual insurance policies could cause carriers to increase premiums dramatically—diluting whatever effectiveness tax credits might have in helping the uninsured afford coverage—or withdraw from the market altogether, according to Neuschler.

Should the Committee elect to approve creation of a tax credit targeted at subsidizing individual health insurance coverage, it is important that the overlap between eligibility for the credit and Medicaid or State Children’s Health Insurance Program (SCHIP) coverage for pregnant women be addressed. Tax credit proposals introduced in Congress and proposed by the Administration in 2003 deny eligibility

<sup>5</sup>Amy B. Bernstein, “Insurance Status and Use of Health Services by Pregnant Women.” AlphaCenter prepared for the March of Dimes. October 1999. [http://www.marchofdimes.com/files/bernstein\\_paper.pdf](http://www.marchofdimes.com/files/bernstein_paper.pdf)

<sup>6</sup>Report 107–233. “Mothers and Newborns Health Insurance Act of 2002.” Committee on Finance, United States Senate, August 1, 2002.

<sup>7</sup>Ed Neuschler, *Policy Brief on Tax Credits for the Uninsured and Maternity Care*. Institute for Health Policy Solutions prepared for the March of Dimes. January 2004.

to individuals enrolled in Medicaid. Because Medicaid income eligibility for pregnant women is more generous than for women who are not pregnant, some tax-credit eligible women will qualify for Medicaid coverage of pregnancy-related services. Under the proposals currently pending before the Committee, these women would be forced to forgo prenatal coverage while covered in the individual market and enroll in Medicaid for coverage of delivery and postpartum care, or to decline private coverage and enroll in Medicaid only for the duration of their pregnancy. If she chose the latter course, the woman would then be forced to re-apply for private coverage—and face possible denial due to underwriting—once her pregnancy is over and she is no longer eligible for Medicaid.

At the very least, pregnant women who become eligible for Medicaid only because of pregnancy should be able to retain their tax credit for individual coverage. The normal third-party liability provisions of Medicaid can assure that Medicaid does not pay for services that the woman's private insurance ought to cover, thus avoiding any risk of duplicative federal costs.

### Alternative Approaches

The March of Dimes urges Members of the Committee to consider the needs of women, especially those who are pregnant, as you tackle the problem of the uninsured. In addition, we offer for your consideration some 'best coverage' suggestions from both the public and private sectors.

1. **If tax credits are considered as a vehicle to help the uninsured, encourage use of the credits for purchase of employer-based or group health insurance, rather than coverage in the individual market.** Because of the difficulties inherent in trying to integrate maternity benefits into individual insurance coverage, it would be preferable if health insurance tax credits were used to expand access to and participation by low-income workers in employment-based coverage and other group plans that cover maternity services. In addition, allowing tax credits to be used for purchase of COBRA continuation coverage through a former employer—as with the Trade Adjustment Assistance health insurance tax credits—would protect some individuals and families from losing coverage that includes maternity care.
2. **Allow states the flexibility to extend SCHIP coverage to pregnant women 19 and older.** Although outside the direct jurisdiction of the Ways and Means Committee, extending the State Children's Health Insurance Program (SCHIP) to income eligible pregnant women is a modest, incremental step that would provide access to maternity services for thousands of women.<sup>8</sup> In 1999, 80 percent of uninsured pregnant women (about 340,000) were eligible for Medicaid or SCHIP but were not enrolled. If SCHIP were expanded as described, and women already eligible for Medicaid were enrolled, *nearly 90 percent of all uninsured pregnant women would have health insurance coverage.*<sup>9</sup>
3. **Automatically enroll newborns whose mothers are enrolled in SCHIP and provide 12 month continuous coverage.** To avoid gaps in coverage for medically vulnerable newborns, enrollment of infants born to mothers eligible for SCHIP should begin on the child's date of birth and continue uninterrupted for at least one year.

### Conclusion

The March of Dimes supports improving access to health coverage for the 12.1 million women of childbearing age and 9.3 million children who are uninsured.<sup>10</sup> As the Committee considers alternative ways of addressing this complex but urgent problem, we ask that you keep the needs of women, especially those who are pregnant, infants and children uppermost in mind.

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<sup>8</sup>The provision to expand SCHIP to cover pregnant women is a component of H.R. 3293, "The Prevent Prematurity and Improve Child Health Act" introduced by Representative DeGette on October 15, 2003.

<sup>9</sup>Kenneth E. Thorpe, Jennifer Flome, Peter Joski. "The Distribution of Health Insurance Coverage Among Pregnant Women, 1999." Emory University prepared for the March of Dimes. April 2001. <http://www.marchofdimes.com/files/2001FinalThorpeReport.pdf>

<sup>10</sup>U.S. Census Bureau, March 2003 Current Population Survey. Data prepared for the March of Dimes. October 2003. <http://www.marchofdimes.com/files/census2003.pdf>

**Statement of Sanford Cloud, Jr., National Conference for Community and Justice**

Madam Chairperson and Members of the Committee, my name is Sanford Cloud, Jr., President and CEO of the National Conference for Community and Justice (NCCJ). The NCCJ, founded in 1927 as the National Conference for Christians and Jews, is a human relations organization dedicated to fighting bias, bigotry and racism in America. With 55 regional offices in 32 states and the District of Columbia, NCCJ promotes understanding and respect for all races, religions and cultures through advocacy, conflict resolution and education. On behalf of NCCJ, I am pleased to submit this testimony to the House of Representatives Subcommittee on Health of the Committee on Ways and Means hearing on the uninsured.

NCCJ has identified racial and ethnic disparities in healthcare as one of our core public policy issues. Looking at healthcare in America, one can see there is a racial and ethnic divide at the most basic level by examining major differences in health insurance coverage by group. Some facts to consider when discussing the uninsured include the following:

- According to the report *Going Without Health Insurance: Nearly One In Three Non-Elderly Americans* (March 2003) released by the Robert Wood Johnson Foundation (RWJ), historically underrepresented racial and ethnic groups are significantly more likely to be uninsured as compared to White non-Hispanic Americans. During the period 2001–2002, 52.2% of Hispanics and 39.3% of African Americans were uninsured, compared to 23.3% of White non-Hispanics for the same period. Among Asian Americans and Pacific Islanders, 17% of children and 24% of adults are uninsured. According to the U.S. Census Bureau, 25.5% of American Indian and Alaskan Natives reported that they did not have health insurance.
- According to the same RWJ report, there were an estimated 39.8 million people in the U.S. population without health insurance in year 2000. However, that number increased to 41.2 million in 2001, and at least 50% of those are people of color. The problem is compounded because those who do have insurance tend to be in lower-end plans, forcing them to pay greater out-of-pocket expenses and reducing their access to medical specialists.
- The disparities in health insurance coverage even exist among those who receive insurance through their employers. The report by the Henry J. Kaiser Family Foundation entitled *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (August 2000) found that only 51% of American Indians and 43% of Hispanic Americans have health insurance through jobs, compared with 73% for White Americans.

NCCJ is addressing this issue through our research, programming and advocacy work. Studies, such as the 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, show that the many factors contributing to the disparities, but can be grouped into three main categories:

- *Socioeconomic disparities*—It is a fact that underrepresented ethnic groups and people of color are disproportionately represented in lower socioeconomic ranks, lower quality schools, and poorer-paying jobs. These factors lead these groups to experience lower rates of insurance coverage and an inability to pay for rising costs of health care.
- *Cultural differences and bias*—The lack of diversity and cultural understanding among health care workers contributes to stereotypes and bias in our health care providers. Increasing the proportion of underrepresented racial and ethnic professionals and integrating cross-cultural curricula will assist caregivers to increase understanding of diversity and background of their patients and increase the trust of the patients in the care and caregiver.
- *Education and language barriers*—Education and language barriers affect the delivery of adequate care through ineffective exchanges of information, misunderstanding of physician instructions, or poor shared decision making. Language difficulties may also result in decreased adherence to medical regimes, low appointment attendance and decreased satisfaction with services.

While much of our work focuses on the non-socioeconomic factors, we understand and agree that part of the solution to eliminating healthcare disparities is based on increasing access to insurance or other affordable healthcare in our communities of color.

Historically underrepresented racial and ethnic populations continue to experience disproportionate rates of morbidity and mortality. Reduced access to quality, affordable and culturally competent healthcare services are critical factors that impact the

health of underrepresented ethnic groups and communities of color across our nation.

Public perceptions of the shape, depth and dimension of healthcare problems vary dramatically depending on one's own background. NCCJ, in partnership with Aetna Inc., conducted a survey that documents the public opinion and perceptions of the problem of racism in healthcare. The report, *Racial and Ethnic Disparities in Healthcare: A Public Opinion Update*, discusses the results.

- Americans do not see racism as an isolated phenomenon: they see it appearing in many aspects of daily life. In healthcare, 64% view racism as a problem, with 20% saying it is a major problem.
- 41% of African Americans see racism in healthcare as a major problem, as do 25% of Hispanics. Only 16% of White Americans say it is a major problem.
- Most Americans say difficulty getting healthcare because of one's racial or ethnic background is not a problem for people like themselves. While only one in five White Americans (21%) see this as a problem, fully 45% of African Americans and 34 % of Hispanics do.
- The public is split on how often a person's race or ethnic background has an impact on whether one can get routine medical care. 40% say it happens very often or somewhat often, while 49% say it is an obstacle less frequently.
- A majority of Americans (55%) say people of color receive the same quality of medical care as White Americans do. Less than a third (28%) disagree; saying African Americans, Hispanics, and other racial and ethnic groups receive a lower quality of care. A substantial majority of White Americans (63%) see no differences in the quality of healthcare, while an almost equally strong majority of African Americans (59%) see lower quality care for people of color. Hispanics are divided on the issue.

NCCJ expresses its high hopes and expectations for the 108th Congress to address the issue of healthcare disparities. Two bills introduced recently, *Healthcare Equality and Accountability Act of 2003* (S. 1833 and H.R. 3459) and *Closing the Health Care Gap Act of 2004* (S. 2091), have the lofty goal of expanding access of quality healthcare through increasing access of affordable health insurance and expanding the health care safety net. With work we can rid our healthcare system of bias, bigotry and racism, and create a system that is more inclusive and just.

Thank you.

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### Statement of the National Federation of Independent Business

On behalf of the 600,000 members of NFIB, we thank you for allowing us to submit testimony today about the worsening health care crisis that faces our country, as the small business community is among the hardest hit. Since 1986, NFIB members have ranked the cost of health insurance as their top concern.

America's small-business owners, whose businesses create two out of every three new jobs in this country, continue to struggle with the high cost of offering health insurance to their employees. Because of the current structure of the health care industry, too many small-business owners and their employees do not have access to affordable health insurance.

A recent Census Bureau report showed that over 43 million Americans lack health coverage. That is an increase of almost 2.5 million people over the previous year and the largest annual increase in more than a decade. In 2002, more than 8 out of 10 uninsured Americans came from working families, with nearly 70% coming from families with one or more full-time workers. It is no coincidence that the uninsured figures continue to rise as the cost of insurance continues to skyrocket—small-business owners face double-digit increases year after year, pricing more of them out of the marketplace.

Many factors contribute to the overall cost of healthcare. Lack of competition in the small group market, litigation, and mandates are just some of the many cost drivers that have led us to where we are today.

Small employers are forced to purchase in the over-regulated small group market, and consequently, workers in the smallest businesses that do provide health insurance pay 17 percent more on average for health benefits than workers at large companies. There is inadequate competition among insurance carriers. A recent GAO survey found dangerously high levels of market concentration among large insurance companies in the states' small group markets. This concentration reduces com-

petition and enhances insurers' underwriting gains; as competition decreases, prices increase.

We must also address the growing cost of benefit mandates. Requiring health insurance to pay for every medical treatment and service covered by state mandates drives the cost so high that the coverage is unaffordable, and therefore, unrealistic. More mandates mean higher costs. The Council for Affordable Health Insurance says that since January 1970, mandates have increased 25-fold.

Something must be done on the front of medical malpractice litigation. The cost of malpractice lawsuits has soared in recent years, pushing up insurance premiums and forcing physicians out of business.

A government run healthcare system is not the solution, however, it is still very much on the minds of some in Congress. The devil is in the details, whether it comes in the form of government-run health care or mandates and minimum benefit packages forced on the backs of small employers.

The problems facing small-business owners, their employees, and families must be addressed as part of the debate. We understand that no one solution will help all of the 43 million uninsured, and, therefore, we propose a multi-faceted approach that will help move countless numbers of Americans off the rolls of those without health care coverage. We are aggressively urging enactment of legislation to permit Association Health Plans—AHPs—to operate nationwide. We support the recently enacted Health Savings Accounts (HSAs), coupled with a high deductible health care plan, as a way for small businesses and individuals to lower their health care premiums. Along with HSAs, individuals should be allowed to deduct 100 percent of their high deductible health plan premiums, if they are not subsidized by an employer plan already. Representative Crane's newly introduced bill, H.R. 3901, would allow for this. Lastly, NFIB supports allowing individuals to rollover Flexible Spending Account (FSA) money from year to year as well as allowing individuals to use tax credits for the purchase of health insurance or toward lowering the cost of their employer-sponsored health insurance plan premiums.

Association Health Plans would allow small-business owners to band together across state lines through their membership in bona fide trade and professional associations to purchase health care for their families and employees. Organizations such as NFIB, the U.S. Chamber of Commerce, Associated Builders and Contractors, and the National Restaurant Association would be able to offer insurance to their members.

Association Health Plans will make health insurance more affordable for small businesses. The Congressional Budget Office has estimated that small firms obtaining health insurance through AHPs will realize premium reductions of 13 percent on average. In fact, reductions range from 9 percent to 25 percent. It is estimated that as many as 2.1 and up to 8.5 million individuals—employees and their dependents—will obtain employer-sponsored health care insurance for the first time due to enacting AHP legislation.

HSAs will also help reduce the number of uninsured Americans by allowing small businesses more choice in the current small group market. For example, some small businesses have saved up to 42 percent when they have chosen a Medical Savings Account (MSA) over traditional insurance products; others have saved up to 60 percent using a Health Reimbursement Account (HRA). Additionally, individuals who have catastrophic health care coverage with a health savings account should be allowed to deduct 100 percent of the premiums from their taxes. HSAs, along with 100 percent deductibility, will provide small businesses with more accessible, affordable options in the health insurance market.

According to a 2001 survey, 80 percent of NFIB members believe that individuals who contribute to tax-free savings accounts for health care should be allowed to carry over any unused portion. Individuals should be allowed to rollover any unspent funds tax-free from year to year. The current limitation of "use it or lose it" needs to be changed to allow workers to take control of health care costs and prepare for the future.

Lastly, small business owners have told us they support tax credits for individuals. With tax credits, small business owners and employees without insurance currently would be more likely to purchase coverage, leaving fewer people without insurance. The credit should be created in a manner that it can be used toward either an individual policy or an employer-sponsored policy. This would provide an opportunity for choice—an employee can purchase a policy based upon his/her individual health care needs. Health insurance policies purchased with the proposed tax credit would also be portable, meaning employees could have the benefit to carry the policy with them to another job and keep the same providers of care through many years, rather than changing providers with each new job.

We cannot afford to wait for the “perfect” solution. There is none. The longer we delay, the more we will hear the calls for government-provided health care, and certainly, *that* is not the perfect solution.

Thank you for holding this hearing that continues the discussion on how to solve the problem of the uninsured.

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**Statement of Martin E. Neltner, Neltner Billing and Consulting,  
Independence, Kentucky**

**Focus on Americans Who Lack Health Insurance Coverage**

**EXECUTIVE SUMMARY**

**Circle of Life and the “Scars” of the Health Care System**

One can sum up the health care crises relating to the uninsured as told by a story where one day my friend the farmer went to see his doctor for a physical. Now this person was never sick a day in 60 years. The farmer noticed that everyone was so busy that he felt bad when they called him back. After all he felt good with the exception of a small tingle in his arm. Because the clinic was busy no one would take the time to ask the pertinent questions about his health. After all he looked healthily so why waste time to ask questions. Two days later my friend the farmer had a stroke that ended up costing the system over \$100,000. So instead of the doctor spending 40 minutes and billing \$ 150 he spent 10 minutes and billed \$60. So the circle of life was broken because now my friend is laid up and he cannot work. His wife can't work because he needs someone to care for him. No taxes were collected on wages and he could not afford his health insurance.

The insurance company hassle factor of putting up roadblocks to pay appropriately backfired and now we have another person who is uninsured. My friend will never be insured again because now he has a pre-existing condition. So if he is able to purchase health insurance it will be costly and it will not cover this chronic condition that was caused by to busy a doctor who is not paid appropriately for the service that in the end cost everyone unnecessary costly health care. Had the doctor spent the time, they would have asked the question “do you have any tingling” the answer of yes would have prompted testing and discover of his risk. Preventive measures would have occurred and my friend would have return to work and continue paying his fair share of being a productive citizen.

There are many “Scars” in the health care system that is causing the uninsured problem. All which are easily repaired. What is needed is for the “Lion King” to return to restore confidence, accountability and responsibility. We need to invoke the principles of the

**“OZ Principle”**

The recent major increases in the premiums by the insurance companies are unjustified. 35% in the past two years alone suggests an out of control system. *Health care is the only industry where there is no accountability and everyone has lost his or her focus.* Hospitals are still inefficient. Doctors have lost confidence and don't care anymore. It's all about the money. After all they just spent 15 years in school and residency, fellowship and paid dearly with long hours of work with little pay. Now they are strapped with school debt, raising families etc. The average mean salary for a primary care doctor is \$90,000. That is an insult to the time they spent learning to care for the sick.

West Virginia along with other states experience a major crises in malpractice. In Cincinnati, Ohio physicians closing up their practices leaving town because the managed care companies would not increase the pay to doctors or hospitals. A large settlement by one insurance company will pay Cincinnati doctors their increases. The other two payers are doing nothing and the suits continue. Charges against insurance companies for Racketeering, low pay, timely payments are increasing all over the country. **CLEAN CLAIMS ACT.** In the last five years virtually every state has had to enact legislation to force insurance companies to pay promptly. The legislation is called “Clean Claims Act”. The problem is the insurance companies have figured out how to get around the term “clean claim so the state legislatures had to return to put teeth into the legislation.



### **The Problem Summarized**

1. Physicians have lost confidence in the system. I don't care and the attitude is "they cheat me so I will cheat back"
2. Hospitals should stay with core business and learn to manage their resources well. Stop the kickbacks and striking deals in secret joint ventures that cause unnecessary increases in health care cost.
3. Patients take health care for granted. Give me a pill to fix my problem. The emergency room rotation of crime, drug addicts, etc. is killing our resources.
4. Every one is sue happy. We need tort reform desperately.
5. The coding system that is used to pay providers invites abuse. It is complex and is designed to send in a 5-digit number and a paycheck appears with no monitoring. Medicare is the only insurance payer that has instituted audits to verify services provided.
6. If hospitals and doctors would collect the small dollar balances health insurance cost could be reduced by 10% to 20% alone. Most providers collect only 50% of what they charge.
7. Stop this nonsense of the doctor dictating a note that creates worthless points to judge the level of care. Ask a doctor and he will tell you 90% of the documentation created in the chart is meaningless. The national coding guidelines managed by the AMA to describe physician complexity in the visit service called the "Evaluation and Management" is causing worthless documentation that cannot tell you much about the patients symptoms and outcome.
8. Resolve the problem of allowing aliens or illegal residents to tax our health care system. The attitude is if you are sick come to America and they will care for you for free.
9. Pushing pill on TV is out of control. I don't need the V drug

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### **The Solution**

#### **Accountability and Responsibility**

Practicing the OZ Principle "Getting Results Through Individual and Organizational Accountability"<sup>1</sup>

1. Restore confidence in the providers who control the spending of the health care dollars by paying more to evaluate the patient symptoms. Make the providers justify their care in a simple documentation process that promotes positive outcomes. I can show you how this would work.
2. Patients must be held accountable for their health. Employers and employees should work together to reduce health care risk.
3. Counter the pushing of pills on TV with more how to care for your health in a natural way.
4. Use Medicare as a model for insurance companies to follow in claims processing. Their system is the best.
5. Better tort reform.
6. Medicare should go into the claims processing business. Insurance companies could contract with Medicare to use their system. Here is an approach based on fact and outcomes. This will offset Medicare administrative cost.
7. Berlin Wall Theory. Require insurance companies to justify their cost. Require meaningful audits of insurance company books. Open the door to hearing about complaints from providers and allow meaningful dialogue to stop abuse, pay promptly and restore confidence between the two parties looking over the Berlin Wall.
8. Allow a simple process for providers to report health care payment abuse. The state department of insurance is worthless.
9. Encourage employers to install wellness programs for their employees.
10. Encourage employers to take positive action and for God's sake we should not wait for the government to solve our health care problem.

The only way to insure those with out insurance is to lower the premium and spread the risk among a lot of people. This is how the system worked before 1984. Ask several insurance companies to pull their resources, and insure those with out insurance. Work with providers to install meaningful systems that reward for symptom management.

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<sup>1</sup> The OZ Principle, Roger Connors, Tom Smith, Craig Hickman.

### Other Comments

1. The physician's pen can be the best tool to curtail health care cost.
2. Pay the physician appropriately for spending time evaluating the patient symptom and developing a plan of action.
3. Stop these foolish audits that derive no benefit. Physicians are scared to code appropriately.
4. The system encourages doctors to see more patients in volume. Its all about quantity and not quality. Refer to graph below.
5. Profiteers in the industry that built small insurance plans 100,000 or less that were purchased and repurchased causing more cost in the system.
6. The charge for the service commonly referred to as the single fee schedule. The phony dollar of what the service is worth. The average industry collection rate.
  - a. Hospitals are paid 30% to 50% of gross charge.
  - b. Doctors are paid 30% to 60% of the single fee schedule.
7. NO ONE IN THE HEALTH CARE SYSTEM KNOWS WHAT IT COST TO PROVIDE THE SERVICE. NO ONE KNOWS WHAT THEIR PROFIT MARGIN SHOULD BE?
8. Insurance company claims processing is a shamble.
  - a. More insurance companies over pay than what you can imagine. Doctors and hospitals play catch me if you can.
  - b. Referrals and authorizations. This system created by the insurance companies is become a legal way to steal from the health care provider.
  - c. THE AMA CODING SYSTEM INVITES ABUSE.
9. **Patients demanding more but will not take care of themselves.**
10. As an employer every time I try to create a system that promotes healthy life styles I get bomb bared with obstacles by the government employees rules that say I cannot do this or that because it discriminates against some one else in the organization.
  - a. As an employer of 84 staff here are my stats.
    - i. 40% are over weigh.
    - ii. 40% eat and drink.
    - iii. 10% drink excessively after work.
    - iv. 10% are chronic depressed.
    - v. 5% have worthless spouses who milk the health care system
    - vi. 65% of my employee smoke
    - vii. There are approximately 10 healthy people in the organization.
    - viii. Absentee is very high, kids are always sick or employee is sick. I have ten employees to cover for the 80 employees who call in sick.

### Office Visit

|             | AMA recommended time per visit | Visits per hour 60 | Physician time per visit | Compared to | Consider this the range |
|-------------|--------------------------------|--------------------|--------------------------|-------------|-------------------------|
| Level one   | 5                              | 12                 | 3                        | 2.4         | ok                      |
| Level two   | 10                             | 6                  | 5                        | 4.8         | ok                      |
| Level three | 15                             | 4                  | 8                        | 7.2         | ok                      |
| Level four  | 20                             | 3                  | 10                       | 9.6         | ok                      |
| Level Five  | 40                             | 1.5                | 15                       | 19.2        | ??                      |

### As it relates to the RVU of each visit

|             | AMA recommended time per visit | Physician time 48% | Staff time 52% |
|-------------|--------------------------------|--------------------|----------------|
| Level one   | 5                              | 2.4                | 2.6            |
| Level two   | 10                             | 4.8                | 5.2            |
| Level three | 15                             | 7.2                | 7.8            |
| Level four  | 20                             | 9.6                | 10.4           |
| Level Five  | 40                             | 19.2               | 20.8           |

So it appears that a physician could see double the number of patients as recommended by the AMA guidelines since in reality his staff is assisting with the evaluation to the degree his efficiency is improved and more billable patients per day are realized.

|                        | Hours | Level II<br>phy time<br>5 | Level III<br>Phy<br>7 | Level IV<br>10 | Level V<br>15 |
|------------------------|-------|---------------------------|-----------------------|----------------|---------------|
| Patients per hour      |       | 12                        | 9                     | 6              | 4             |
| 8 till 12              | 4     | 48                        | 34                    | 24             | 16            |
| 1 till 5               | 4     | 48                        | 34                    | 24             | 16            |
| Total patients per day |       | 96                        | 69                    | 48             | 32            |
| Payment per service    |       | 34                        | 48                    | 75             | 91            |
| Payment per day        |       | \$3,264.00                | \$3,291.43            | \$3,600.00     | \$2,912.00    |
| Works 4 days a week    |       | 4                         | 4                     | 4              | 4             |
|                        |       | \$13,056.00               | \$13,165.71           | \$14,400.00    | \$11,648.00   |
| Weeks worked           |       | 48                        | 48                    | 48             | 48            |
|                        |       | \$626,688.00              | \$631,954.29          | \$691,200.00   | \$559,104.00  |
| Take home rate         |       | 0.52                      | 0.52                  | 0.52           | 0.52          |
| Take home              |       | \$325,877.76              | \$328,616.23          | \$359,424.00   | \$290,734.08  |

